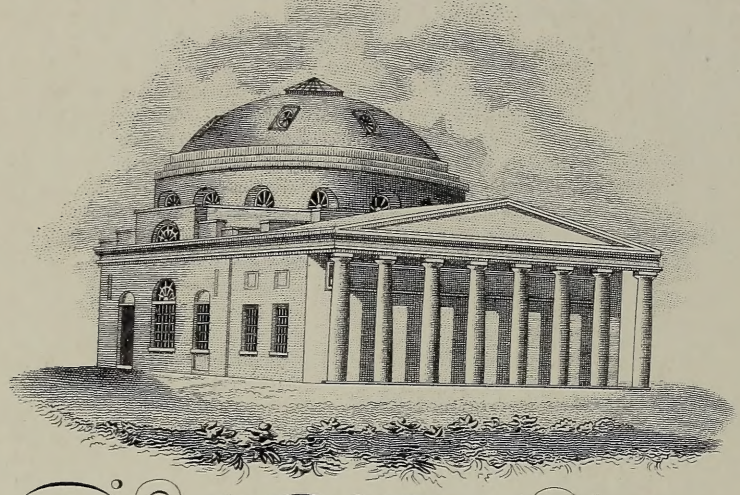
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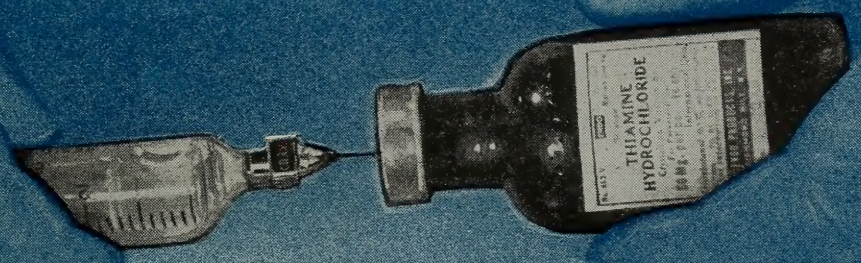


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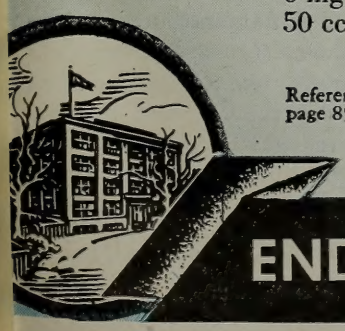
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Reference: Williams, Robert R.; Spies, Tom D.; "Vitamin B_1"; Macmillan (1938) page 89.



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The Physician's Bookshelf

Diseases of the Breast, by Charles F. Geschlickter, M.D., ($12.00. 2nd Ed. *J. P. Lippincott Co., Philadelphia)* is a complete monograph. One of of the most interesting parts of the text is the summary of the author's experimental studies in cystic mastitis and practically all varieties of benign and malignant mammary tumors have been produced in the rat and the rabbit.

Clinical Biochemistry, by Abraham Cantarow, M.D., and Max Trumper, Ph. D., ($6.50. 3d Ed. *W. B. Saunders Co., Philadelphia)* brings this subject up to date with extensive supplementation and revision of the material in more than 40 topics.

How a Baby Grows, by Arnold Gesell, M.D., ($2.00 *Harper & Brothers, Publ., New York City)* tells the story with over 800 photographs. It covers everything from birth through the first year. Its author is the well known Director of The Clinic of Child Development at Yale University. A valuable reference for all who work with children and an interesting guide for parents.

A Textbook of Healthful Living, by Harold S. Diehl, M.D., Dean of Medical Sciences, University of Minnesota, ($2.50. 3d Ed. *McGraw-Hill Book Co., Inc., New York City)* brings up to date this authoritative, readable, and practical guide to healthful living by including the latest developments in the fields of nutrition, vitamins, physical fitness, immunity, the military control of insect borne diseases, normal sex life, etc., etc.

Honey and Your Health, by B. F. Beck, M.D., and Doree Smedley, ($3.00. *Robert M. McBride & Co., New York City)* comments on all phases of the problem—nutritional, medicinal, and historical. A most interesting compilation.

One Hundred Years of Gynaecology, 1800-1900, by James V. Ricci, M.D., ($8.50. *The Blakiston Co., Philadelphia)* is a companion volume to *The Genealogy of Gynaecology,* which was a valuable historical document bringing us up to 188 A.D. from 2000 B.C. This volume is, in addition, a reference work and covers the Nineteenth Century. It will prove most helpful to all who write on a gynecologic subject.

A Guide on Alcoholism for Social Workers, by Robert Victor Seliger, M. D., and Victoria Cranford, ($2.00 [paper] or $3.00 [cloth]. *Alcoholism Publications, Baltimore, Md.*) has been written by a Hopkins psychiatrist and director of the Farm for Alcoholic Patients, Howard County, Maryland. It is a series of valuable and helpful papers on the subject.

Cadet Nurse, by Peggy Gaddis, ($2.00. *Arcadia House, Inc., New York City*) is the story of a young woman who buried herself in a hospital while her lover went to the wars. Excellent tale and might help some young girl that you know make up her mind to become a nurse.

Nurse Merton on the Russian Front, by Louise Logan ($2.00. *Arcadia House, Inc., New York City*) is as dramatic a mystery story as we have read in a long time.

The Story of Penicillin, by Boris Sokoloff, M. D., ($2.00. *Ziff-Davis Publ. Co., Chicago*) ,is a detailed non-technical account of the infections that penicillin will cure and how it cures. The book gives its reader an intelligent understanding of a medical miracle which has captured the imagination of the world.

Virus as Organism. Evolutionary and Ecological Aspects of Some Human Virus Diseases, by Frank M. Burnet, M. D., ($2.00 *Harvard University Press,* Cambridge, Mass.) is a collection of the Dunham Lectures. The volume will bring you up to date on this very pressing subject.

Modern Urology for Nurses, by Sheila M. Dwyer, R. N., and George W. Fish, M. D., ($3.25. 2nd Ed. *Lea & Febiger, Philadelphia*) brings up to date this valuable manual.

Cherry Ames, Army Nurse, by Helen Wells, ($0.60. *Grossett and Dunlap, Inc., New York City*) is a portion of the life of our old heroine —another thrilling story of a brave, lovable girl. Fascinating pictures of the Army Nurse Corps.

Everyday Psychiatry, by John D. Campbell, M.D., ($6.00. *J. B. Lippincott Co., Philadelphia*) is concise, clinical, and practical. For 30 years I have been trying to understand and classify for my personal use the thing the psychiatrists have written. Here, for the first time, I have found a book which makes this possible. I am now going back to see what the others were trying to say. What I am saying is, that this is the most practical book for the rest of us.

Oral Health, by H. Shirley Dwyer, D. D. S. ($1.25. *W. B. Saunders Co., Philadelphia*) is an excellent text for all who have to do health teaching.

Pulmonary Edema and Inflammation, by Cecil K. Drinker, M. D., ($2.50. *Harvard University Press, Cambridge, Mass.*) is an analysis of processes involved in the formation and removal of pulmonary transudates and exudates, a subject which most of us do not know enough about.

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JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.* GEORGE H. SAVILLE, *News Editor*

Increased Intracranial Pressure and the General Practitioner's Responsibility

JOSEPH P. EVANS, M. D.

AT first glance the above title might suggest little of interest to the general practitioner, if only because the appearance in general practice of a patient presenting increased intracranial pressure is relatively infrequent. However, when one remembers that increased intracranial pressure may be a complicating factor in a number of conditions, including brain tumor, brain abscess, hydrocephalus, intracerebral hemorrhage, arterial hypertension, and generalized infections of the central nervous system, one readily sees that the problem may present itself in mort individuals than is at first thought.

Its recognition may be of paramount importance in the individual patient because it constitutes a grave threat to the patient's survival and therefore, though not frequently appearing on the general practitioner's horizon, his responsibility is nonetheless very real and his place in the patient's welfare is very important. The neurological surgeon, faced with the problem of relieving the pressure or of removing the causative agent, is always grateful to the alert practitioner because increased intracranial pressure accentuates the technical problems and militates against the satisfactory solution of a particular case, and hence adds gravely to case mortality.

THE CEREBROSPINAL FLUID

The cerebrospinal fluid is formed by the choroid plexuses. These arterially supplied tufts of specialized epithelium lie in the lateral, the third, and the fourth ventricles. The method of formation of cerebrospinal fluid, whether by filtration, osmosis, or some other physico-chemical process, is not clearly understood.[1] It is, however, a well-known fact that obstruction of the cerebrospinal fluid pathways leads to the building up of a head of intracranial pressure above the point of obstruction, which ultimately approaches the arterial diastolic pressure.[2, 3]

The unobstructed cerebrospinal fluid circulates from the lateral ventricles through the narrow foramina of Monro into the slit-like third ventricle, thence through the aqueduct of Sylvius into the fourth ventricle. From here the fluid escapes by way of the laterally-placed foramina of Luschka and the median foramen of Magendie into the subarachnoid spaces; a small fraction of it descends downward and bathes the spinal cord, and it is estimated that about one-twentieth of the cerebrospinal fluid is absorbed into the venous circulation around the spinal nerve roots.

The balance of the fluid makes its way up-

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ward, apparently chiefly by way of the subarachnoid spaces beneath the medulla and pons, upward through the opening in the tentorium into the upper cranial cavity. From here it makes its way over the convexities and eventually is absorbed into the venous circulation by way of the pacchionian granulations. These granulations are present chiefly along the major venous channels, particularly the median longitudinal sinus, but also in some of the larger cortical veins, particularly near the midline.

THE PRESSURE

Thus, fluid that is formed in the choroid plexuses under a potentially very high pressure eventually reaches the venous circulation at what is in the erect position of the patient a negative pressure. In the ventricular system there are several points at which obstruction can relatively easily occur; either foramen of Monro, the third ventricle, the aqueduct of Sylvius, or the outlets from the fourth ventricle. Obstructions within the ventricular system give rise to internal hydrocephalus. It is also possible for obstruction to occur in the external system, the subarachnoid spaces. Such obstruction is particularly prone to occur around the base of the brain, as in the occasional cases of obstructive hydrocephalus following incompletely resolved leptomeningitis.

It is then legitimate to think of mechanical obstructions occurring either in the ventricular or in the extra-ventricular fluid spaces. These obstructions may occur from space consuming lesions, which near the narrow ostia and passageways may be relatively small; or which in the case of remotely placed space-consuming lesions, may through generalized shift of cerebral substance cause an eventual obstruction of fluid passage. Aside from localized space-consuming lesions, however, it seems not unlikely that there may occasionally occur acute increases in fluid content of the brain, the mechanism of production of which is as yet not completely understood. One thinks in this connection particularly of the crises of hypertensive encephalopathy, in which there may occur sudden sharp rises in the intracranial pressure as measured at lumbar puncture.

DISTURBANCES

The physiological disturbances which result from increasing intracranial pressure have fundamental significance to the patient, and the physician should have the mechanism clearly in mind. Extracts from two papers of the late Doctor Harvey Cushing will serve to emphasize the importance of the physiological mechanism:

"The fact that cerebral compression occasions a rise in blood pressure is universally known but it does not seem to have been recognized that the degree of this elevation occurs **pari passu** with the degree of compression (measured in millimetres of mercury) to which the medullary centres are subjected. It is ordinarily stated by the numerous experimentors who have dealt with problems of compression that fatal symptoms originate when the intracranial pressure approaches or reaches the height of the arterial tension. The fact that the arterial tension is a varying quantity which regulates itself so as to overcome the effects of the increased intracranial pressure seems never to have received attention.[2]

" . . . . . This rise in blood pressure represents a purposeful and not a meaningless reaction. The belief was expressed in a regulatory mechanism which controls the rise, and which, under experimental circumstances at all events, is seemingly so adjusted that the vasomotor centre tends to hold the intravascular pressure (arterial tension) at a level slightly in excess of the external (extravascular) pressure exerted by the compressing force against the arterioles and capillary vessels situated in the medulla. In this way a fatal bulbar anemia, which otherwise would be the result of an equalization of intracranial and a stationary arterial tension, is warded off. Thus, the high-pressure pulse, which characterizes conditions of intracranial hemorrhage, for example, is easily accounted for, and its measured level of tension may be taken as an indication of the degree of circulatory embarrassment from which the medulla is suffering in consequence of the compressing force.

"It was pointed out that under these circumstances the continuance of respiration hinged upon the efficiency of the vasomotor mechanism in holding the blood pressure at a certain level. Should the vasomotor centre fail to keep the arterial tension in excess of the experimentally increased intracranial tension, the respiration would immediately cease, owing to the anemia of the centre governing it. . . . . the sequence of events in case of immoderate intracranial tension is, primarily, exhaustion of the vasomotor mechanism with fall in blood pressure, and, secondarily, failure of respiration in consequence of the ensuing bulbar anemia." [3]

EXAMPLES

As examples of these physiological disturbances I should like to cite three cases. The first of these illustrates a condition closely approximating the state of affairs produced experimentally by Doctor Cushing in his early work, the second is a typical example of brain tumor in a child with its attendant disturbances of lesser degree than those cited in the first case, and the third case emphasizes the depressant effect of increased intracranial pressure upon the level of consciousness.

Case 1. There was seen at the Children's Hospital a young child suffering from an obstruc-

tive hydrocephalus due to occlusion of the lower end of the aqueduct of Sylvius. For undetermined reasons the partial occlusion of the aqueduct increased to the point where frank signs of intracranial pressure had developed, and he was therefore brought to the hospital for study. An unsuccessful attempt was made to cannulate the aqueduct of Sylvius, and following this operative procedure complete occulsion and a rapid increase in intracranial pressure occurred. Early in the day following the operative attempt at relief he was found to be deeply comatose, his pupils were widely dilated, he did not respond to strong supraorbital stimulation, the deep reflexes were absent, there were bilateral plantar extensor responses, respirations were reduced to four per minute, and his skin was purple and blotchy. It was obvious that if the intracranial pressure were not relieved he would die, and probably in a matter of a few minutes.

Small trephine openings had been made over the occipital region at the time of the operative procedure, and through one of these a needle was introduced into one of the lateral ventricles. There immediately occurred the escape of fluid from this ventricle, and the intracranial pressure was promptly (though only temporarily) reduced because fluid was being released from above the point of the obstruction in the aqueduct of Sylvius.

In about a minute he began to stir restlessly. Shortly after the dilated pupils began to reduce in size. In two minutes he responded to questioning. At the end of five minutes his physiological status seemed to have returned to about normal.

There would seem to be no question but that the return to normalcy was made possible because the sharply increased intracranial pressure was reduced to a point well below the arterial pressure, and it again became possible for the blood to circulate freely within the intracranial cavity. This example seems a clear-cut confirmation (there are many others in the clinical literature) of Doctor Cushing's early experimental observations. The case is included here to emphasize the dramatic changes that occur in the face of, and following the relief of, increased intracranial pressure.

Case 2. The second case illustrates other aspects of the same problem. The birth and developmental history of this three year old, colored child had been entirely negative. She began to walk at the age of 16 months, and at the age of 2½ was a very active, perfectly normal child. Throughout this time she apparently had occasional, rather severe headaches, judging by periods of restricted activity in which she would complain of head pain. Shortly after this her mother observed that her hat appeared to be becoming a little small. Three months before entry the child began to vomit occasionally, and the episodes of headaches appeared to become more frequent. It was about this time that it was observed she was a little unsteady in walking. One week before entry the child complained that she could not see clearly. It was this complaint that led to her admission to the hospital.

Examination showed a well developed, fairly well nourished colored child of 3, who was cooperative. General physical examination was normal, except that the head appeared large and on percussion there was a rather high-pitched note equal bilaterally. The gait was found to be broadbased and when in the "quadriped position" she could easily be thrown off balance by a sudden push. The neurological examination further showed bilateral papilledema, about 4 diopters, with fresh hemorrhages in both retinas, but no abnormality in the pattern of the retinal vessels. Visual acuity appeared to be somewhat reduced. There was a paresis of the right lateral rectus muscle. The cranial nerves were otherwise negative. There was generalized hypotonicity of the muscles of the extremities. The deep reflexes were diminished throughout and there were bilateral Babinski responses. Finger to nose test and heel-knee-tibia tests were well done. Sensation was normal.

X-rays of the skull showed a large sella with washed-out clinoid processes, well defined hammered silver markings of the skull, and a suggestion of separation of the sutures. A lumbar puncture was not done.

A suboccipital craniotomy was carried out and a tumor of the cerebellum was exposed; a biopsy was made. When this showed the tumor to be a medulloblastoma the wound was closed and subsequently X-ray therapy was given.

Case 3. The third case illustrates other elements to be considered in connection with the problem of increased intracranial pressure.

This eight year old child had enjoyed apparently excellent antecedent health until about two weeks before the entry to the hospital when she complained of headache and was observed to become irirtable and less active. A few days before admission she vomited on several occasions.

Examination showed a normal appearing child, whose general physical examination was not remarkable, except for a pulse rate ranging between 60 and 70. Neurological examination revealed early papilledema, an equivocal left homonymous hemianopia, and slight accentuation of the deep reflexes on the left.

X-rays of the skull showed a suggestion of "hammered silver" effect, slight enlargement of the sella, and thinning of the clinoid processes.

Lumbar puncture showed an initial pressure of 250 mm. of water, 80 lymphocytes, a positive Pandy, and a total protein of 50 mg. per cent. This cerebrospinal fluid Wassermann and gold curve were negative.

Under observation the child continued to vomit for the next few days, and rather suddenly one afternoon became drowsy and unresponsive. She was taken to the operating room and a temporal lobe abscess was drained. She then went on to an uneventful recovery.

These then are rather typical examples of increased intracranial pressure. Most of the answers as to what the general practitioners should look for as warnings of increasing intracranial pressure are contained in the above case reports.

RECAPITULATION

By way of recapitulation, some of the cardinal symptoms and signs may be set out here again. Headache, a symptom common to many bodily ailments, should be regarded with suspicion if it be persistent, severe, and unresponsive to general medical measures. It may be particularly significant when associated with vomiting. Not all projectile vomiting represents vagal irritation from increased intracranial pressure; on the other

hand vomiting due to this cause need not be projectile. An enlarging head in an infant or a young child is an almost positive sign of increased intracranial pressure. The development of extraocular palsy, particularly a paresis of the lateral rectus muscle, may represent local pressure upon the nerve of supply to the involved muscle. The occurrence of papilledema is, of course, of extreme significance; and the routine use of the ophthalmoscope would reveal many cases of intracranial pressure at an earlier stage than otherwise.

Lest the impression be created that determinations of the arterial tension are of particular help in detecting developing intracranial pressure, it ought to be emphasized that such changes occur relatively late, and usually only when grave danger is imminent. Bradycardia is a better warning of danger than is arterial hypertension, particularly when associated with vomiting it should be regarded with suspicion. Drowsiness is a sign of considerable importance; oddly, frequent yawning, the mechanism of which is not known, may be a useful indicator. When drowsiness gives over to stupor and when it is associated with other signs of increased intracranial pressure, one knows that the danger point of intracranial decompensation is near. A drop in respiratory rate is very apt to develop in the late stages of increased pressure.

LUMBAR PUNCTURE

A word of warning should be interjected at this point concerning the use of lumbar puncture in determining the height of the intracranial pressure. The danger of lumbar puncture is a moot point. Munro, with a wide experience in the treatment of head injuries, stated in 1943 that he hoped the ghost of the danger of lumbar puncture had finally been laid.[4] It is my own belief that if the ghost has been laid, it should again be disinterred, and I hope that we may some time in the near future present the evidence in support of this contention. In the meantime, it is my opinion that if the intracranial pressure is sharply increased as determined by lumbar puncture, only a minimum amount of fluid should be removed at the time of the diagnostic puncture because of the danger of herniation of the medulla through the foramen magnum, or of the brain stem through the opening in the tentorium.

In any event, the general practitioner is the patient's first line of defense against the ravages of increased intracranial pressure. If those lesions which produce such increase in pressure and which are susceptible to surgical attack are to be recognized at the earliest time, when conditions are favorable to effective surgical attack, responsibility for that recognition rests squarely upon the shoulders of the general practitioner. The alert one will know the basic anatomical and physiological principles and will have an understanding of the mechanism of production of increased pressure and of the accompanying signs and symptoms, and will above all make effective use of the diagnostic methods which will reveal the presence of the increased pressure, of which method the intelligent use of the ophthalmoscope is probably the most important.

SUMMARY

1. The recognition of increased intracranial pressure is an important responsibility of the general practitioner, since it is he who first sees the patient who presents this disturbance in normal physiology.

2. The early recognition of increased intracranial pressure is of great importance because the technical problems presented to the neurological surgeon increase, one might say, in geometrical proportion to the delay in recognition.

3. The circulation of the cerebrospinal fluid, some possible causes of obstruction in its free flow, and the compensatory mechanisms which stave off for a time its evil effects are reviewed.

4. Several typical examples of the clinical picture presented by increased intracranial pressure are cited.

5. The clinical signs indicative of increased intracranial pressure are reviewed, and the responsibility of the general practitioner in detecting them is again emphasized.

BIBLIOGRAPHY

1. Merritt, H. H., and Fremont-Smith, F.: The Cerebrospinal Fluid. W. B. Saunders Company, Philadelphia, 1938, pp. 333.

2. Cushing, H.: Concerning a Definite Regulatory Mechanism of the Vaso-Motor Centre Which Controls Blood Pressure During Cerebral Compression. The Johns Hopkins Hosp. Bull., Vol. XII, No. 126, September, 1901.

3. Cushing, H.: The Blood-Pressure Reaction of Acute Cerebral Compression, Illustrated by Cases of Intracranial Hemorrhage. Amer. Jr. Med. Sci., June, 1903.

4. Munro, D.: The Treatment of Cranio-Cerebral Injuries with Especial Reference to the Non-Operative Group. Res. Publ. Ass. Nerv. Ment. Dis., Vol. XXIV, Trauma of the Central Nervous System, 635-658, 1945.

Tuberculosis still ranks as our seventh or eighth cause of death. The major problem which confronts us, in this case, is early diagnosis; but this term no longer means the diagnosis of clinical disease by fever and a cough and loss of weight. It means diagnosis before clinical disease occurs at all—diagnosis through the magic of the X-ray. In many individuals, tuberculosis can be arrested even after clinical symptoms have appeared. In other instances, it is by that time too late. The keystone of our program must be the discovery of early lesions in the lung at a time when the keenest diagnostician with his stethoscope can observe no clinical abnormality.—C. E-A. Winslow, Survey Graphic, April, 1945.

Tantalum Cranioplasty

JOHN T. BAKODY, M. D.

AN ideal substitute material for the repair of cranial defects should be readily available, easily worked, strong enough to withstand ordinary trauma, and biologically inert. The search for such a material has been accelerated by World War II. Many materials have been used in the past including cartilage and bony grafts, celluloid, plastics, and metals.

The autogenous grafts consist of rib-cartilage or bone derived from the ribs, tibia, ilium, or scapula, or from the adjacent skull, using a Müller-König technique. Ney reported 44 cases of autogenous bone cranioplasties in 34 of which there was either partial or complete absorption of the grafts; while Grant and Norcross noted absorption of the graft in but three of 58 cases. The obvious advantage in the use of autogenous material is that since the living tissue of the host is used there is no foreign body reaction. However, multiple operations are often required, cartilaginous grafts always remain cartilage, are never solid and often times present poor cosmetic results.

HISTORICAL NOTES

The search for a satisfactory alloplastic material has been continuous since Jacob von Meekren in 1670 used a dog bone to repair a skull defect in a Russian peasant. (Which later had to be removed because the Church held that God's image in man had been defiled.) Ney reported on the use of celluloid in the repair of three hundred cranial defects with only five failures, in 1939. While celluloid is readily available and easily worked it is a foreign body, is not rigid, and may become soft and ineffective.

Geib, and Peyton and Hall, in 1941; and Beck in 1942, described the use of vitallium plates for the closure of cranial defects. Vitallium is an alloy of cobalt, chromium and molybdenum. The material is very hard and must be cast. This necessitates an accurate foreknowledge of the size and shape of the cranial defect and in many cases demands a two-stage operative procedure. Beck circumvented this disadvantage to some extent by employing curved strips of vitallium so that any size defect could be latticed over.

The more or less successful use of other metals, including aluminum in 1893 and again in 1915; gold in 1895 and 1915; silver in 1917; platinum in 1929; and ticonium in 1942; has been reported.

The availability, malleability, strength and biological inertness of tantalum in sheet form has made tantalum the material of choice for the repair of skull defects at the present. Tantalum is the 73rd element and occurs in group five of the periodic series. It is a basic element having the physical properties of cold rolled steel and the chemical properties of glass. Ekeberg, a Swedish investigator, discovered it in 1802, naming it after Tantalus, the hapless son of Zeus. Its density is 16.6 (about twice that of steel). Its small co-efficient of expansion makes changes in the size of the metal insignificant in the range of body temperatures. It is virtually non-magnetic and its chemical inertia obviates galvanic and tissue reactions.

In 1942, Pudenz and Odom, demonstrated that tantalum was admirably tolerated by the brain substance and meninges. The following year, Pudenz reported an experimental study on the repair of cranial defects with tantalum. He implanted tantalum plates one-fiftieth inch in thickness into the cranial defects in eleven cats. Postoperatively, no marginal necrosis of bone had occurred and after sacrifice of the animals it was found that the tantalum plates were enveloped in delicate translucent layers of connective tissue which were continuous with the pericranium. The capsule was completely formed at the end of 27 days and showed no tendency to progressive thickening. The inner layer was adherent to the dura but easily separable from it. Osteoblastic activity was noted in all cases with a tendency to closure of the cranial defect by new bone formation over the inner surface of the cranial plate. Shortly thereafter, Fulcher reported what was probably the first case of a human cranial defect repaired by tantalum on November 24, 1941. Since that time other reports have appeared in the literature.

In 1944, Major Robertson reported a series of

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Read, by invitation, before the Chicago Surgical Society, May, 1945.

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26 cases of tantalum cranioplasty in servicemen. Tantalum sheet metal 15 and 20 mills thick was used. The skull defect was mortised in each case. In some cases the pre-formed plate was locked into position by its inherent spring without further fixation. Wiring and glazier point technique was also employed. The Major advocated immediate repair of skull defects resulting from acute cranial trauma as part of the routine treatment. This was done even in the presence of soiled wounds. No complications were reported as a result of following this procedure.

THE SERIES

The present series consists of some 40 cases of tantalum cranioplasty in Naval Personnel. Interesting experiences which were gained in this group of cases will be mentioned later.

Tantalum sheet is made in thicknesses of 10, 15, 20, and 25 mills. In this group of cases tantalum sheet of 15 and 20 mills has been employed. A metal sheet of such thickness is easily worked and there is reason to believe that a 20 or 25 mill thickness is preferable. This was illustrated in the case of a patient with a sizeable right fronto-temporal skull defect as a result of surgical removal of bone for osteomyelitis. Almost two months following insertion of a 15 mill tantalum plate over the defect the patient was in an automobile accident where his head struck the steering wheel resulting in denting of the tantalum plate. The edges of the plate were not displaced but there was a depression of the anterior part of the plate to a depth of more than half an inch in which one could place the heel of his hand. The patient complained of headache localized to the depressed area. The plate was removed, the dura opened and the underlying brain found to be grossly normal. The plate was worked back to its original shape and replaced.

It is advisable to perforate the plate. This does not weaken the plate appreciably and allows the soft tissues to grow through the holes in the plate, to obliterate the dead space between the plate and the scalp. In one case a large right frontal skull defect was repaired and for cosmetic reasons the perforation of the plate was omitted. Postoperatively, fluid accumulated between the tantalum plate and the over-lying skin. This persisted despite repeated aspirations and three months later it was necessary to re-operate, remove the tantalum plate, perforate it, and replace it. There was no accumulation of fluid following the second procedure. At the time of re-operation a definite cyst was encountered between the plate and the overlying scalp. The cyst-wall was glistening, egg-white in appearance and somewhat translucent. The membrane extended over the external surface of the plate and was found to grow through the peripheral fixation holes, becoming continuous with a similar glistening membrane covering the skull defect, and adherent to the dura.

Oftentimes the skull defect is covered with scar tissue, which derives its blood supply from beneath. In one such case the scar was included in the center of a scalp flap, and was reflected with the flap after being dissected free from the tissue beneath. After insertion of a tantalum plate between the superficial scar and its previous blood supply, the central scar of the flap became necrotic and sloughed, necessitating a secondary plastic procedure. It is therefore advisable to resect all sizeable superficial scars in a primary scalp revision operation, and to later insert the plate. Furthermore, any latent infection residing in the scarred area will be given an opportunity to manifest itself, and should not complicate the secondary insertion of the plate.

AFTER EFFECTS OF TREPHINES

The "syndrome of the trephined" was described by the French during the first World War. It consisted in headache, usually local in type; vertigo; amnesia, inability to concentrate the attention, insomnia, etc. The idea that symptoms could arise from a skull defect per se has been ignored in favor of the view that such symptoms reflect the actual brain damage associated with the original trauma or operation. Gardner has recently revived the older notion, and he points out that the replacement of a yielding scar by a non-yielding substance (as tantalum) reconverts the pulsating brain into a nonpulsile organ, and puts an end to the pathologic mobility of the brain.

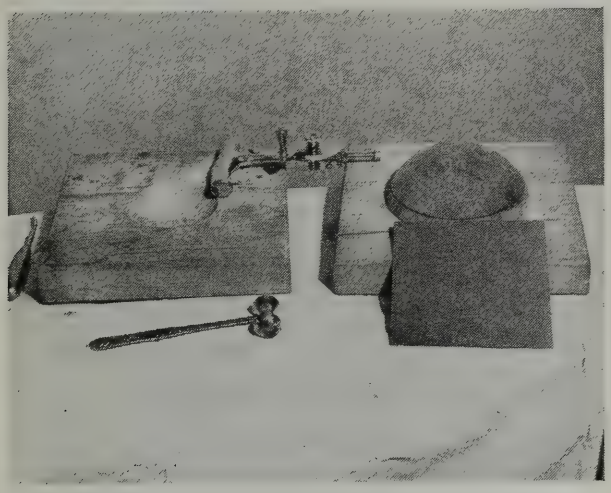
A consideration of these facts leads one to the conclusion that the surgeon should include cranial defect repair as part of his treatment of brain wounds. The optimum time for such repair can only be determined by future experience. Present opinion varies from immediate repair, to a wait of several months.

In addition to the foregoing, the indications for cranioplasty include:

1. The restoration of external symmetry of the skull—cosmetic improvement.
2. Removal of adhesions, which by tugging on the brain may produce epilepsy.
3. Prevention of redevelopment of adhesions.
4. Relief of painful or pulsating defects.
5. Protection from trauma.
6. Psychological security for the patient.

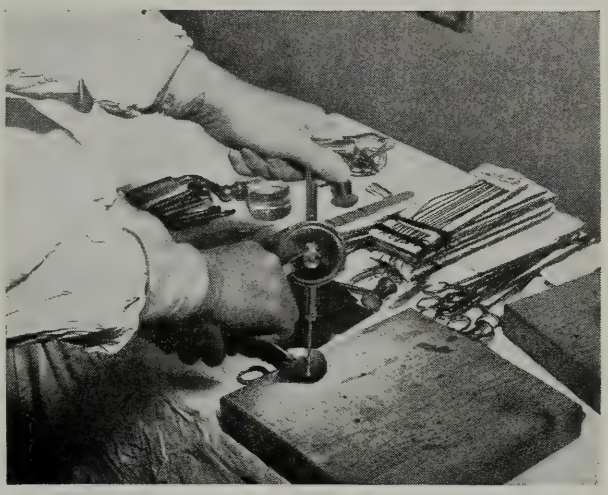
No special preparation of the bony defect for the reception of the tantalum plate is required. The outer table of the bony rim of the defect may be chiseled or rongeured to provide counter-

sinking for the plate but ordinarily this is not necessary. It does no harm for the thin plate to extend somewhat beyond the limits of the skull defect. Tantalum plate has been implanted directly over the denuded cerebral cortex without any apparent ill-effects. Postoperatively there may be a tendency for fluid to accumulate between the scalp and the tantalum plate but this fluid may be aspirated and if the plate is perforated, it will not reform. Black silk technique has been employed in the closure of the scalp flap.



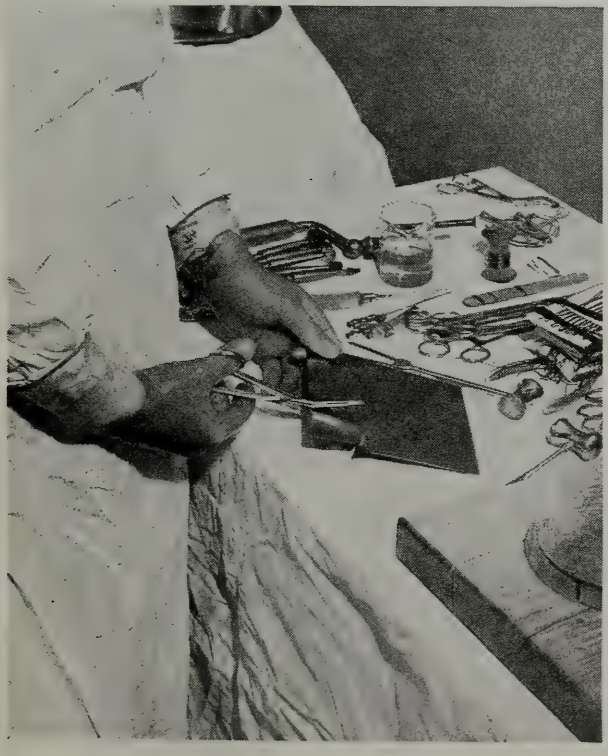
1. A 6x6" sheet of 20 mills tantalum is leaning against a wooden form used in working the plate.

Tantalum sheet can be formed into plates to repair skull defects, by hammering or die moulding. In the latter method a preoperative model of the skull defect may be made with the use of dental impression wax and from this a master mould made of dental stone. A die is then made of dental stone and the tantalum sheet formed in a press having a capacity of several tons total pressure with the use of a rubber pressing pad as a male die. This procedure has been developed by the Fan Steel Metallurgical Corporation.



3. The plate is perforated with a Sherman hand drill.

The former method, that of hammering, requires a rudimentary knowledge of the art of forming metals by hand and a skill acquired by practice. This method is relatively simple and the method of choice, I believe. Curved wooden forms and a ball type hammer for working the tantalum sheet are useful. In old skull defects where underlying bony and metal fragments are to be dealt with, one can not know in advance the size cranial defect that the surgeon, himself, will create at the time of operation. In such a case the surgeon can cut the sheet to fit the resulting defect, hammer the



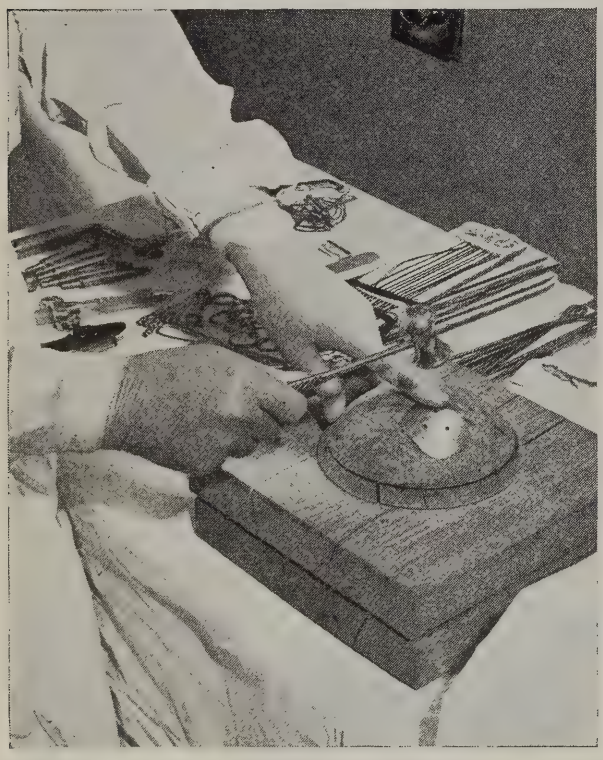
2. The plate may be cut in the operating room using heavy bandage scissors.



4. The plate is formed with a ball hammer using first a concave form.

plate into shape and confine himself to a single operative procedure.

The tantalum plate should be secured to the skull although some men lay the fitted plate into the mortised defect with no fixation other than the suture of soft tissues over the plate. The use of screws, wiring and tantalum glazier points has been described. Tantalum screws have not been generally available, but this method should prove very satisfactory. Popular is the use of small triangular wedges of tantalum which are hammered into the diploë to secure the tantalum plate after the fashion of a glazier securing a windowpane. These tantalum wedges should be 20 or 25 mills thick to prevent buckling



5. And then drawing it on a convex form.

of the wedges. Three or four tantalum wire sutures to secure rigid fixation of the plate to the skull, is practicable.

CONCLUSION

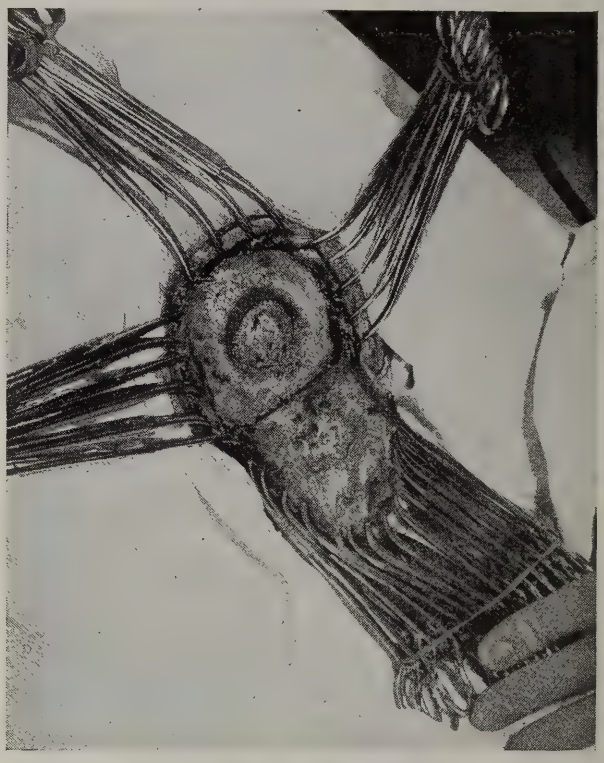
In conclusion, it may be stated that an ideal substitute material for the replacement of cranial defects has been discovered and is being employed with practical success. Tantalum sheet in 20 or 25 mill thickness is readily available, biologically inert and easily worked by hand to any desired shape. The plate may be inserted into cranial defects resulting from acute cranial trauma as part of the treatment of the original injury, if desired. The plate should be perforated and adequately secured. Such a repair provides protection against further trauma, is psychologically sound and cosmetically satisfactory.

REFERENCES

Grant, F. C., and Norcross, N. C.: Repair of Cranial Defects by Cranioplasty, Am. Surg. 110; 448-512, Oct., 1939.

Peer, L. A.: Types of Buried Grafts used to Repair Deep Depressions in the Skull, J. A. M. A. 115; 357-360, Aug. 3, 1940.

Ney, K. W.: The Repair of Cranial Defects with Celluloid. Am. Jr. of Surg. 44; 394-399, May, 1939.



6. A horseshoe flap has been turned to expose a right parietal skull defect.



7. The bony edges of the defect have been mortised, a perforated and drawn plate has been accurately fitted into the defect and secured with three small wedges of tantalum driven into the diploë.

Geib, F. W.: Vitallium Skull Plates. J. A. M. A. 117, B-12, July 5, 1941.

Peyton, W. T., and Hall, H. B.: The Repair of a Cranial Defect with a Vitallium Plate. Surg. 10: 711-715. Nov., 1941.

Beck, C. S.: Repair of Defects in Skull by Ready Made Vitallium Plates. J. A. M. A. 118:798-799, March 7, 1942.

Burke, G. L.: The Corrosion of Metals in Tissues and an Introduction to Tantalum. Canad. Med. J., Feb. 1, 1942, Vol. 74, Pp. 231-235.

Pudenz, R. H., and Odom, Guy L.: Meningocerebral Adhesions. Surg. Vol. 12, No. 2, Aug., 1942. Pp. 318-344.

Pudenz, R. H., Lt. (j.g.) USNR: The Repair of Cranial Defects with Tantalum. J. A. M. A., Feb. 13, 1943, Vol. 121, Pp. 478-481.

Fulcher, O. Hugh, Lt. Comdr., MC, USNR, "Tantalum as a Metallic Implant to Repair Cranial Defects." J. A. M. A., March 20, 1943, Vol. 121, Pp. 931-933.

Robertson, R. C. L., Major: Repair of Cranial Defects with Tantalum. Jr. of Neurosurg. 1: 222-236, July, 1944.

Campbell, E., Meirowsky, A., Tomkins, V.: Studies on the Use of Metals in Surgery. Am. Surg. 116: 763-775, 1942.

Pankratiev, B. E.: Dead Bone Grafts to Repair Skull Defects. Am. Surg. 97: 321-326, 1933.

Gardner, W. James: Closure of Defects of the Skull with Tantalum. S. G. & O: 303, March, 1945.

Blood Pressure by Palpation

This is a method by which both systolic and diastolic blood pressure may be determined.

Technique: After placing the blood pressure cuff on the upper arm, the first finger of the examiner's hand (right or left depending on arm used for blood pressure) is inserted under the cuff directly over the brachial artery. The cuff is now inflated until pulsations are no longer felt. Then pressure in the cuff is reduced slowly. The first pulsations perceptible to the finger correspond to the systolic pressure. The pressure is reduced until pulsations are no longer felt; this corresponds to the diastolic pressure.

This method is successful only if the finger under the cuff is not pressed against the artery by the examiner (only pressure of the cuff is used).

Advantages: (1) This method may be used in a noisy room or by one with impaired hearing. (2) It is faster (although just as accurate with practice) and easier on the ears than the auscultatory method during mass physicals.

Precaution: The pulse in the examiner's finger may be confused with that of the brachial artery if the examiner is not adept.

Following its use on 1,500 Army inductees, the palpatory method was found to be equal in accuracy to that of the older method. Before relying on this method it is recommended that auscultation and palpation be used simultaneously until the examiner is familiar with the technique.

WM. G. HUTCHINS, M.D., Columbus, Ohio.

The person who realizes that he has tuberculosis is more likely to take better care of himself and be more on guard against spreading his infection than if he is ignorant of the fact that he has the disease. John L. Rice, M.D., N. Y. State Jour. of Med., Feb., 1945.

Surgical Treatment of Hypertension

I may begin by saying that the surgical treatment of hypertension is and has been for the last twelve years in the experimental stage. The first operations done deliberately to lower hypertension were based largely on empiricism; upon the observation, for example, that when a spinal anesthesia was produced, with the level somewhere above the middle thoracic region, there was a concomitant fall in blood pressure It was reasoned from such an experience that one might, with selective operation, cut vasoconstrictor nerves supplying the large vascular bed in the splanchnic area and the lower extremities, and thus permanently lower blood pressure. Unless one believes or can show that there is some advantage in lowering the blood pressure by this means, there is no other useful purpose for the operation. I believe, therefore, that operation can be evaluated solely on its ability to lower the blood pressure. There are some who maintain that elevated blood pressure is only one manifestation of hypertensive vascular disease, and that lowering the blood pressure will have little or no benefit on the patient who has such disease. Until or unless that can be proved, the operation, if it can lower the pressure, deserves continued usage, since evidence can be presented which suggests that there are advantages in association with the lowering of the blood pressure.

Until recently, the surgeons have been occupied with finding a suitable operative method, one that would be practical, as nearly complete in its sympathectomizing effect as possible, and reasonably safe for the patient. The first operation consisted in extensive laminectomy and division of many anterior spinal roots, thereby interrupting the sympathetic outflow to the splanchnic region. This was a formidable operation, and was destined to be replaced by something more practical. There followed then for several years a variety of operations designed to interrupt the sympathetic pathways in the paravertebral area, that is, outside of the spinal region. One of these consisted in cutting the sympathetic pathways in the thorax above the diaphragm. Another one consisted in interrupting the pathways below the diaphragm.

The operation which we now employ, which has been in use now for about five years (at our hospital for about four years)), and which is often referred to as the Smithwick operation, is a thoraolumbar sympathectomy. It removes a very large portion of the sympathetic supply to the splanchnic vascular region and to the lower extremities, and it is done in such a way that the possibility of regeneration of the sympathetics is greatly diminished.—Dr. B. S. Ray, New York City, in "Conference on Therapy", N. Y. St. Med. Jr., Vol. 45, No. 23, Dec. 1, 1945.

Progress and Stasis in Medicine: Perforation of Colon By a Chicken Bone

W. M. JOHNSTON, M.D.

WE desire to submit the report of an emergency case to illustrate the progress of recent medicine and surgery. This is a case that a few years, perhaps even three years ago, would have had no opportunity whatsoever of survival—but under modern methods and armamentarium, did recover and return to his occupation, like many hundreds who have and many thousands who will under these recent methods, all of which should be a source of pride to the profession. But the anti-climax shows that we should not let our pride go too far.

On Tuesday P. M., May 29, 1945, a male patient, 53 years of age, was admitted to the Akron City Hospital by Dr. R. A. Gregg who referred the case to me for surgical consultation and treatment.

The patient at first glance appeared acutely ill, with the history that on Sunday, May 27, at about 1:00 P. M. as he was about to leave his shift while working in the rubber factory, a sudden acute pain hit him in the abdomen and he could hardly complete his work. However, he did, and was able to get home and go to bed. The cramps continued more severe than he had ever had in his life. But the family secured all types of sedatives at the drug store, so that he did not call a physician until nearly 48 hours later, when he stated "he realized something would have to be done". During all this time his bowels did not move nor did he vomit, but he did not take any cathartics.

Past history was essentially negative except that he had been having irregular abdominal cramps and loss of appetite for the past two weeks which he attributed to irregular eating habits and poor restaurant food. He also had a few chest pains which seemed to go down his left arm.

He had an appendectomy about 30 years previously at which time drainage had been used.

On admission a flat plate of the abdomen was taken and the report stated that "There were three loops of dilated small bowel in the left mid-abdomen which I believe represent a definite small bowel obstruction. There is no gross evidence of large bowel obstruction."

On physical examination the patient was found to be the type who was greatly resistent to pain. However, it also showed a very acute abdomen with generalized tenderness and rigidity and some distension. No definite area could be marked out as the cause of the acute condition either by abdominal or rectal examination.

He had an old right rectus scar from former appendectomy, which was irregular and showed the usual signs of former drainage, but since there had been no vomiting and since there was nothing in the history that might account for a large bowel obstruction, we made a diagnosis of acute peritonitis, cause unknown, but that an exploration was indicated.

A Wangensteen suction tube was inserted into the stomach, 1,500 cc. 5 per cent glucose in saline administered and the patient was sent to surgery.

Under spinal anesthesia a left rectus incision with retraction of the muscle was made. On opening the abdomen a general peritonitis with dark colored fluid and free pus was found. There were several areas of small bowel distension with early adhesions; several loops of the ileum were beginning to show definite early gangrene.

The pelvis was explored very carefully and a mass felt in the lower sigmoid just above the rectum; our first impression was that it was a malignancy with secondary perforation; but closer examination revealed a thickened, edematous granular infection of the sigmoid with an acute perforation caused by a chicken bone over three inches in length. It was one-half of the so-called "wish-bone".

Suction was employed, the chicken bone removed. No attempt was made to close the chronic edematous perforation, but a catheter was inserted into the opening and brought out through a stab incision as a temporary colostomy. Drains were inserted into the pelvis and the abdominal incision promptly closed.

The resident's notes when the patient was returned to bed were "condition critical, prognosis poor". But then the real treatment started un-

Submitted September, 1945.

The Author

● Dr. Johnston, Akron, Ohio, is a graduate of Ohio State University College of Medicine, 1925; and associate staff member, Akron City, People's, St. Thomas and Children's Hospitals.

der modern methods and drugs, no baby doses but "the works":

Semi-Fowler's position constantly;

Morphine gr. ¼ q 3 h;

Phenobarbital grs. II by hypo p. r. n.;

Intravenous 1,200 cc. of 5 per cent glucose in saline b. i. d. with 3 grams of sulfathiazole in each intravenous;

Blood transfusion 250 cc. of blood with each intravenous for several days;

50,000 units of penicillin stat and 25,000 units q 2 h which was gradually decreased in time and amount.

We have found the small transfusions often, with penicillin more effective than single large transfusions.

The patient did not die as expected with such an abdomen, but gradually began to show improvement.

During the first critical week he had 15,000 cc. of glucose and saline; 1,500,000 units of penicillin; 2,250 cc. of blood and plasma. The Wangensteen suction with gradual clamping off was continued for seven days.

The colostomy catheter was removed on the 12th day. He was allowed out of bed on the 15th day and his strength slowly returned. He was allowed to return to his home on July 10, completely ambulatory and without complaint. He had an excellent appetite and a gradual gain in weight. All concerned considered this a recovery entirely due to modern and recent medical knowledge.

We had almost forgotten that in his past history he had stated that he had a few pains in the left chest which had radiated strongly to his left arm in the last year. Our patient was able to return to work on August 2.

On August 6 he came to the office to have some final papers completed in regard to his hospital insurance. He was feeling wonderful.

On August 10, I discovered he had attended some races and had quite a strenuous day.

On the afternoon of August 11 their family physician being away, I received in my office a sudden, frantic call from his sister that something serious must have happened to him, and would I come right out.

When I arrived I found our patient was dead lying right across the bed where he had fallen from a heart attack.

As I looked at our patient I thought that was an easy death, but I also thought we men of medicine have made a wonderful advance and performed miracles with our new technique and drugs, yet, we must never become too conceited as we still have a lot to learn about the old and common complaints of mankind.

KEEPING UP WITH MEDICINE

PRENATAL period is the most important in life. It is the period when effective and intelligent nutrition teaching would result in the greatest gains to national health.

* * *

THERE are frequent examples of the fact that the increased requirements of this period, superimposed upon a mild deficiency, result in frank deficiency symptoms in the mother.

* * *

ONE often wonders about the traces of things in drinking water.

* * *

TODAY the terms **menopause** and **climateric** are carelessly used as interchangable. Menopause refers to the permanent cessation of the menses while the climateric is supposedly a critical period of life of which there are many.

* * *

WHY is it that athletes almost invariably make better records outdoors than indoors?

* * *

THE elements most frequently present in excess, sometimes to a dangerous extent, are lead, arsenic, fluorine, and selenium.

* * *

CHRONIC low abdominal rightsided pain requires appendectomy only when the chronic pain has been interrupted by attacks of acute appendicitis recognized by pain beginning near the umbilicus, associated with nausea, vomiting or change in bowel habits, and final localization with tenderness over McBurney's point, leukocytosis, and fever.

* * *

THE fetus is parasitic upon the mother only to a certain extent, and that extent is limited by the mother's nutritional state at the time she enters the pregnancy and by the quality and quantity of her diet.

* * *

ALL food-treating processes, except quick freezing, unfortunately tend to remove or imbalance vitamins and minerals.

* * *

WHETHER the precipitation and removal of essential elements, such as calcium, magnesium, iron, zinc, cobalt, and copper from drinking water by present treatments has any significance for the health of the communities using treated water should be settled by thorough research.

* * *

IT is possible by selection of the correct natural foods to correct all of the deficiencies and excesses of our diets.

* * *

ANDROGENS are valuable in impotence when this disorder is directly caused by hypogonadism.—J. F.

Case Report of Congenital Right Diaphragmatic Hernia With Autopsy Findings

F. W. McDOWELL, M.D., and J. M. TONDRA, M.D.

DIAPHRAGMATIC herniae have been reported often, but right diaphragmatic herniae are rare enough to warrant reporting another case. Eight thousand autopsies at Johns Hopkins Hospital, reviewed by James White[1], disclosed but one case of right sided hernia. Harrington[2], of the Mayo Clinic, reports only one case of hernia through the right hemidiaphragm in a series of 304 diaphragmatic herniae and it was in an adult. He reported two cases of hiatus pleuro-peritonealis hernia in adults and six cases in children, but did not state on which side they occurred. Four of these herniae contained right colon and small bowel, but no liver; therefore it is doubtful whether they were right sided herniae since their position was not mentioned. Likewise his report includes five cases of Foramen of Morgagni herniae in adults with no liver or right colon included in the hernial contents.

THE CAUSES

The causes of diaphragmatic hernia will be considered briefly. Anatomically there are five weak spots through which congenital or acquired hernia occur. They are the esophageal hiatus, the right and left parasternal openings or the Foramen of Morgagni and the right and left pleuroperitoneal openings or the Foramen of Bachdalek. Callender[3] briefly mentioning the development of the diaphragm states that:

> "The diaphragm arises from five morphological elements: the central tendon, two ventrolateral and two dorsal parts. The central tendon is formed from the transverse septum, an embryonic layer of tissue separating the heart from the liver. The ventrolateral portions of the diaphragm arise from the ventrolongitudinal muscle layer of the body. The dorsal portions are derived from the paravertebral musculature. These segments fuse and leave a pleuroperitoneal foramen on each side posteriorly between each dorsal and ventrolateral part. These apertures close early in fetal life by a fusion of their margins."

Sometimes through lack of coordination of development herniation tends to occur through the lines of incomplete fusion. Congenital herniae are sometimes through the dome of the diaphragm[4] or through the gap left by the absence of a hemidiaphragm or a portion of the diaphragm.

Submitted September 25, 1945.

The Authors

● **Dr. McDowell, Canton, Ohio, is a graduate of Indiana University School of Medicine, 1943; formerly resident in surgery at Mercy Hospital, Canton; now Lt., Med. Corps, A.U.S., on active duty.**

● **Dr. Tondra, Canton, Ohio, is a graduate of Creighton University School of Medicine, Omaha, 1943; and senior resident in surgery at Mercy Hospital.**

Diaphragmatic herniae are often classified as true hernia when they have a sac or false hernia when there is no sac present. Our case presented an elliptical dehiscence of the right hemidiaphragm with no hernial sac.

CASE REPORT

The patient was a male infant weighing 7 pounds 13½ ounces who was delivered without difficulty on May 18, 1944, at Mercy Hospital, Canton, Ohio. The infant was resuscitated with some difficulty, although there were no obvious abnormalities. On May 20, 1944, it was noted that the infant nursed poorly and exhibited one short period of cyanosis. On the fifth day of life the baby began to vomit brownish bloody material and dyspnea and cyanosis became marked.

Physical examination at this time revealed dullness to flatness throughout the right chest. The heart and trachea were deviated to the left. X-ray revealed dense clouding throughout the right chest blending with the liver shadow. Dr. Geo. Popoff, roentgenologist, reported that extensive visceral herniation through the right diaphragm should be considered primarily. Dr. A. W. Warren was called to see the patient and he advised an exploratory thoracotomy under local anesthesia.

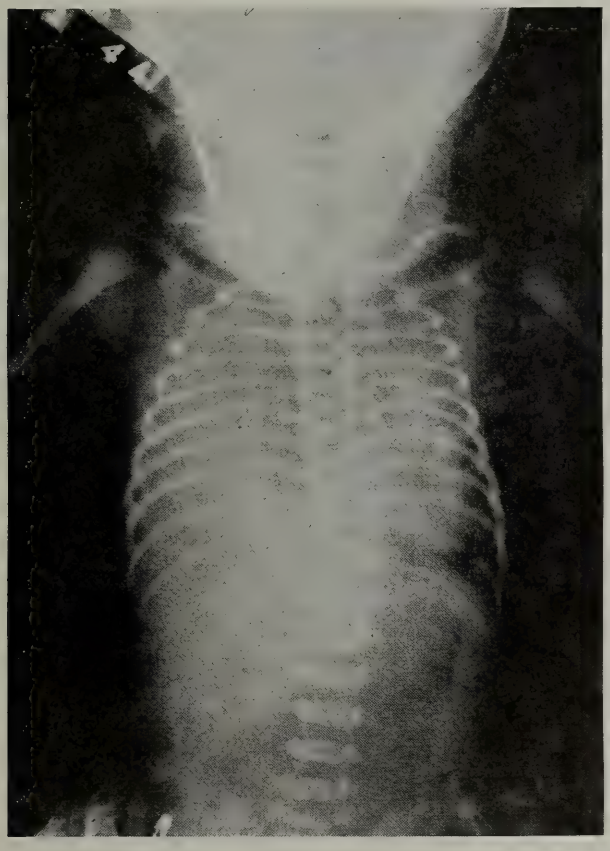
The thoracotomy revealed that the right pleural cavity was filled with abdominal viscera and that the right lung was atelectatic. Most of the colon, some of the small intestine and a portion of the right lobe of the liver were in the pleural cavity. With great difficulty these viscera were manipulated and finally reduced into the abdominal cavity exposing a large elliptical defect in the anteromedial portion of the right leaf of the diaphragm. No hernial sac was present. The edges of the defect were freshened and joined together with interrupted cotton sutures. The pleura and skin were then closed without drainage.

Oxygen was administered throughout the en-

tire operation, but the infant's condition became precarious as soon as the liver was reduced into the peritoneal cavity. Restorative measures failed and the patient expired.

AUTOPSY

An autopsy was performed by Dr. R. S. Rosedale. A quadrilateral mass of liver tissue constituting about one-fourth the normal size of the liver was connected to the main portion of the liver by a coarse insular neck of fibrous and hepatic tissue. The gallbladder and associated ducts were imbedded in this quadrilateral lobe of the liver. When the dehiscence of the diaphragm was reestablished by removing the sutures, the quadrilateral lobe of the liver could be rotated through the defect in the diaphragm into the right pleural cavity. There was no anomaly of the portal vein or pancreas. There was a mesial rotation of the upper pole of the left kidney and adrenal. The colon showed some degree of malrotation, the cecum being high and displaced to the left, almost to the midline and



Roentgenogram demonstrating the extensive visceral herniation in the right thorax above the liver shadow.

at the level of the umbilicus. There were two accessory partial lobulations of the upper lobe and one of the lower lobe of the right lung. The middle lobe was not well defined. There was extensive congenital atelectasis of the right lung and some atelectasis of the left lung. The heart chambers were dilated.

DISCUSSION

The above case is of unusual interest for three reasons. First, because the patient had a right diaphragmatic hernia with one-fourth of the liver and a good portion of the intestinal tract in the thorax, which is a rare finding. Moreover the defect was in the anteromedial portion of the right crus; the usual site being in the posterolateral region where fusion occurs. Although other congenital defects were present, none were incompatible with life, if the diaphragmatic hernia could have been remedied.

Secondly, it is noted that the repair was attempted during the fifth day of life. However, Harrington has pointed out that these repairs should be done as soon as possible, because the longer the interval between birth and the surgical repair the more difficult the reduction and repair of the hernia. This is because the abdomen does not increase in size to accommodate the viscera as the child grows and the enlarging thorax increases the size of the defect. Harrington prefers the abdominal approach for left diaphragmatic hernia and the thoracic approach for the right diaphragmatic hernia. In this case the infant's preoperative state was so precarious that the thoracotomy should be considered an emergency measure, not as elective surgery. In spite of the large size of the hernia, it was closed quite satisfactorily; a child a few weeks older would have been much more difficult to operate.

Third, it is interesting to consider the possibility of respiratory and circulatory failure from pressure changes caused by reduction of the hernia. This infant withstood the operation well until the liver was reduced into the abdominal cavity. Oxygen therapy alone was inadequate; if oxygen had been administered under positive pressure, respiratory and circulatory collapse may have been avoided or controlled. Harrington advocates the study of each patient with X-ray following the repair of the hernia and withdrawal of air from the pleural cavity, if there is a mediastinal shift. He also believes that the operation is more successful if the phrenic nerve on the side involved is temporarily interrupted. He strongly advocates the use of positive pressure control of respiration during the operation.

SUMMARY

1. The incidence and embryology of congenital right diaphragmatic hernia is reviewed.

2. An unusual finding of congenital right diaphragmatic hernia in an infant is reported.

3. Surgical treatment is discussed.

4. Early operation with anesthesia and oxygen under positive pressure is advocated.

BIBLIOGRAPHY

1. White, J. C.: Right Sided Diaphragmatic Hernia. Bull. Johns Hopkins Hosp., 1925, 37:203-213.

2. Harrington, S. W.: Diaphragmatic Hernia of Children. Ann. Surg., 1942, 115:705-715.

3. Callender, C.: Surgical Anatomy, 2nd Ed. W. B. Saunders Co., 1942, pp. 237-239.

4. Christopher, F.: A Textbook of Surgery by American Authors, 3rd Ed. W. B. Saunders Co., 1942, pp. 1390-1396.

A Case of Perforative Diverticulitis of the Colon In a Twenty-Seven Year Old Male*

OLIVER EITZEN, M.D.

DIVERTICULITIS of the colon occurs with considerable frequency in patients past 50, but is less common in cases between 30 and 50 and decidedly uncommon in those below 30. Acquired diverticula or diverticulosis, the precursor of diverticulitis occurred in 5.2 per cent of cases[1] as determined by a large group of autopsy and roentgenographic statistics. In their own series Young and Young[1] found the incidence of diverticulosis to be 38 per cent of those patients studied by barium enema. Karsner[2] states that the incidence is 25 to 30 per cent of all adults. In 300 consecutive autopsies, the incidence at St. Alexis Hospital was 8.6 per cent. In people below 30, however, diverticulosis is unusual. Of a total of 596 cases, Brown & Marcley[3] found only one occurring in the third decade. Bearse[4] states that the average incidence under 30 is .31 per cent of all cases of diverticulosis.

The Author

● **Dr. Eitzen, Cleveland, Ohio, is a graduate of the University of Kansas School of Medicine, 1939; member, Cleveland Society of Pathologists; pathologist, St. Alexis Hospital; and instructor in pathology, Western Reserve University School of Medicine.**

CLINICAL HISTORY

G. K., a white male, age 27, was admitted to the hospital with complaint of abdominal pain. This pain began approximately two hours before admission at which time it was generalized. It soon localized in the right lower quadrant and was sharp, severe, and "colicky". It was associated with nausea and vomiting and became progressively worse. The past history was not notable, except that the patient was discharged from the army one year previously because of "psychoneurosis". After operation it was learned that the patient, while in the army, had repeated attacks of diarrhea thought to be a "nervous" manifestation.

Physical examination revealed a well developed and well nourished male with temperature of 100.2°F., pulse rate 92, and respiration rate 20. The positive observations were limited to the abdomen. There was abdominal as well as rebound tenderness, most prominent over the right lower quadrant. Epicritic hyperesthesia was noted over McBurney's point.

The white blood count was 13,300 and hemoglobin was 12.75 gm. A differential revealed 80 PMN, 19 lymphocytes, and 1 monocyte. The urinalysis was negative except for a trace of albumin and 2-4 WBC per high power field.

At operation, the peritoneum was found hyperemic and dull with areas of fibrino-purulent exudate. This same change was noted over the appendix which was removed (pathological diagnosis: acute peri-appendicitis). The stomach and small intestines were normal except for their serous surfaces. The sigmoid colon was thickened and firm. A Penrose drain was inserted in the region of the sigmoid colon and 10 grams of sulfanilamide were sprinkled into the peritoneal cavity.

The immediate postoperative condition was good. For several days following the operation, there was only moderate elevation in temperature and slight abdominal distention. On the fifth postoperative day the temperature went up to 104° F. and thereafter the patient became seriously ill. He developed a cough and dullness over the bases of the lungs was noted. The abdomen became more distended and tender and an indefinite mass developed in the left lower quadrant. In addition to general supportive therapy, penicillin was begun on the second postoperative day. The initial dose was 40,000 units and thereafter 20,000 units were given intramuscularly every four hours. Blood transfusions and "Amigen" were given from time to time. On the eleventh postoperative day penicillin was discontinued and sodium sulfathiazole was given intravenously (5 gm. initial dose and 2.5 gm. twice daily thereafter).

For a time the patient was in an oxygen tent. An incision and drainage over the mass in left lower quadrant of the abdomen was performed on the eleventh postoperative day and considerable pinkish-yellow pus was siphoned off. At this time the patient's condition was poor and four hours later he died.

AUTOPSY

The heart was enlarged weighing 425 gm. In the mid-portion of the interventricular septum was a grayish brown, firm area which measured 4 x 2 x 1.5 cm. All of the coronary arteries showed marked sclerosis and there was marked narrowing of the lumen in the anterior descending branch of the left. Fibrin and pus were over all of the peritoneal surfaces. In the sigmoid colon were six diverticuli, one of which was widely perforated.

Microscopic examination revealed extensive fibrosis of the myocardium in the interventricular septum and sections of the descending branch of the left coronary artery showed marked intimal fibrosis and thickening with marked narrowing of the lumen. The peritoneal surfaces were covered by acute fibrino-purulent exudate. There was necrosis and infiltration with neutrophilic leucocytes, as well as lymphocytes and plasma cells about the area of the perforated diverticulum. Other diverticula were composed

*This case was presented with permission of V. F. Pekarek, M.D.

Submitted October 19, 1945.

of mucosa, muscularis mucosa, and serosa with little or no muscularis. They showed no significant inflammatory change.

Anatomical diagnoses: acute suppurative perforative diverticulitis of the sigmoid colon, diverticulosis of the sigmoid colon, diffuse acute fibrino-purulent peritonitis, remote infarct of the heart (interventricular septum), marked coronary artery sclerosis, hypertrophy and dilatation of the heart (425 gm.).

COMMENT

Diverticula of the large intestine are frequently silent. When inflammation occurs, various symptoms arise. The acute symptoms are usually similar to those of any acute intra-abdominal inflammation and may resemble those of appendicitis closely, including fever, vomiting, and leucocytosis. The abdominal tenderness is ordinarily most prominent on the left side. If perforation occurs theer are often manifestations of shock and peritonitis. Diverticulitis, however, is frequently chronic and then the symptoms may be those of nausea, dull pain in the abdomen, most often on the left, and frequently diarrhea. On the other hand, there may be obstruction. In the case reported here, the predominance of signs in the right side of the abdomen led to a preoperative diagnosis of appendicitis. Had the previous history of frequent bouts of diarrhea been known at the time of operation, the diagnosis of diverticulitis might well have been seriously considered.

The cause of diverticulosis is not known. Diverticulitis is most commonly caused by irritation due to inspissated feces. This may lead to early perforation and peritonitis. Perforation, however, may not occur and in these cases, peridiverticulitis and colitis follow. This inflammation may rapidly subside but also it may progress with formation of much granulation tissue and cicatrization, which may cause obstruction of the colon. In this type of complication, a diagnosis of carcinoma is sometimes erroneously made.

The treatment of diverticulitis depends on the complications present. If there is perforation, obstruction, or extensive localized inflammation, surgical operation is indicated. Where the differentiation between diverticulitis and carcinoma can not be made, operation may also be necessary. In general, the most conservative type of surgery applicable to the case is advised.

BIBLIOGRAPHY

1. Young, E. L., and Young, E. L. III: Diverticulitis of the Colon. Review of the Literature and Analysis of Cases. New England Jr. Med., 230:33-38, Jan. 13, 1944.

2. Karsner, H. T.: Human Pathology. J. B. Lippincott Co., 1942.

3. Brown, P. W., and Marcley, D. M.: Prognosis of Diverticulitis and Diverticulosis of the Colon. J.A.M.A., 109: 1329-1333, Oct. 23, 1939.

4. Bearse, C.: Acute Perforative Diverticulitis of the Colon in Young Persons. J.A.M.A., 113: 1720-1722, Nov. 4, 1939.

Medical Jargon

The following phrases include many of those which physicians use frequently in speaking and in writing. They come within the classification of "Jargon" and as such should be replaced with the more accurate terms as listed. (From "Medical Writing. The Technic and the Art", by M. Fishbein, A.M.A., Chicago, 1938.)

JARGON	CORRECT EXPRESSION
cardiac (diabetic, nephritic) diet	diet for a patient with cardiac disease (nephritis, diabetes mellitus)
surgical abdomen	acute surgical condition within the abdomen
surgical interference	surgical intervention
Neisserian	gonorrheal
luetic	syphilitic
lues	syphilis
specific	not syphilitic, pyogenic, bacterial
right lower quadrant	lower quadrant of the right side of the abdomen
upper left quadrant	upper quadrant of the left side of the abdomen
right heart failure	failure of the right side of the heart (or) failure of the right ventricle
left-sided failure	failure of the left side of the heart (or) left ventricular failure

—ROBERT G. LEHMAN, M.D.

Renal Hypertension

During the past decade experimentation has evolved a satisfactory explanation of the pathogenesis of arterial hypertension on a renal basis.

Thirty patients with renal disease and coexistent hypertension who had undergone nephrectomy have been reviewed. There were 20 patients who showed improvement; 5 who showed no change, and; 5 who experienced a rise in blood pressure following nephrectomy. The average age of the improved patients was 38 years and those showing an increased blood pressure, 54 years. There was a minimal amount of arteriosclerosis in the improved patients and a moderate to marked degree was present in the patients with a rise in blood pressure. Of the 5 patients who had no marked change in blood pressure or subjective symptoms after nephrectomy 3 were found to have renal disease in the remaining kidney, 1 had hypertension of long duration due to a congenital disease, and 1 had a familial history of hypertension.—Charles E. McKeown, M.D., Milwaukee, Wisc.; The Wisc. Med. Jr., Vol. 44, No. 12, Dec., 1945.

Soil in Relation to Health

C. R. ORTON, PH.D.

WHEN I accepted your kind invitation to address this distinguished audience, I had no intimation that I would be placed on this program at such an auspicious hour as eleven o'clock Sunday, the hour when sermons are being delivered throughout the Land. While I am not a preacher and far less a clergyman, I have always been a reasonably consistent attendant at church and I feel it particularly fitting, therefore, to open this address by excerpts from the Old Testament, Genesis I. I do this because they form the background for the subject I am going to present to you today—"The Soil in Relation to Health".

"In the beginning, God created the heaven and the earth. And the earth was without form, and void; and darkness was upon the face of the deep. And God said, Let there be light, and there was light. . . . . And God said, Let there be a firmament in the midst of the waters, and let it divide the waters from the waters. And God made the firmament and divided the waters which were under the firmament from the waters which were above the firmament. . . . . And God said, Let the waters under the heaven be gathered together in one place and let the dry land appear: and it was so. And God called the dry land Earth, and the gathering together of the waters he called Seas."

Thus it was that the primary natural resources were created—the inorganic world. **First**, sunlight, without which no living thing can exist—the sole source of energy essential in the natural synthesis of plant food for animal and man. **Second**, the atmosphere, which in biblical terms is called the firmament or sky—again a primary resource essential to all forms of life except the anaerobic. **Third**, water; and **Fourth**, the dry land. These last two primary resources are largely within the province of man to conserve. Water enters into every cell of every living thing and is the element which has had most to do with shaping the topography of the earth as well as the direction of mankind since his creation. The appearance and disappearance of civilizations have gone hand in hand with this resource, water, and its availability with respect to both quantity and quality.

The dry land certainly refers to the mineral elements which composed the earth's crust before life appeared. These mineral elements are essential also to all forms of life. Without them life would be without differentiated form if indeed life would be possible without the mineral elements. It may be of interest at this point to call attention to the intimate relationship of water and minerals in the program of conserving our natural resources. If man will hold the water where it falls, the conservation program is solved for most practical purposes. Outside the removal of mineral elements by plants, water is the most important agent in removing these elements from the place where they can be utilized by man. Our soil conservation program is fortunately almost wholly a water conserving plan, at least in its early stages. If this were not so it would be most unfortunate, for in conserving the soil we are more or less unconsciously conserving the most important primary resources amenable to man's influence—**water!**

Thus I have dealt with the primary natural resources; all inorganic and all essential to every form of life. Let us turn now to the organic world, next treated in the First Book of Moses. "And God said, Let the earth bring forth grass, the herb yielding seed, and the fruit trees yielding fruit after its kind, whose seed is in itself, upon the earth." Here then we behold the creation of the first group of secondary natural resources, the **plants**, which constitute the great intermediary for the conversion of the mineral elements in combination with organic materials into infinite forms of food for man and animal. The plants were the necessary precursors of the next group of secondary resources, the **animals**, which according to Moses appeared as follows, "And God created great whales, and every living creature that moveth, which the waters brought forth abundantly, after their kind, and every winged fowl after his kind." And finally the animal kingdom was completed with the creation of man which, according to the version in Genesis, occurred as follows, "And God said, Let us make man in our image, after our likeness; and let them have dominion over the fish of the sea, and

The Author

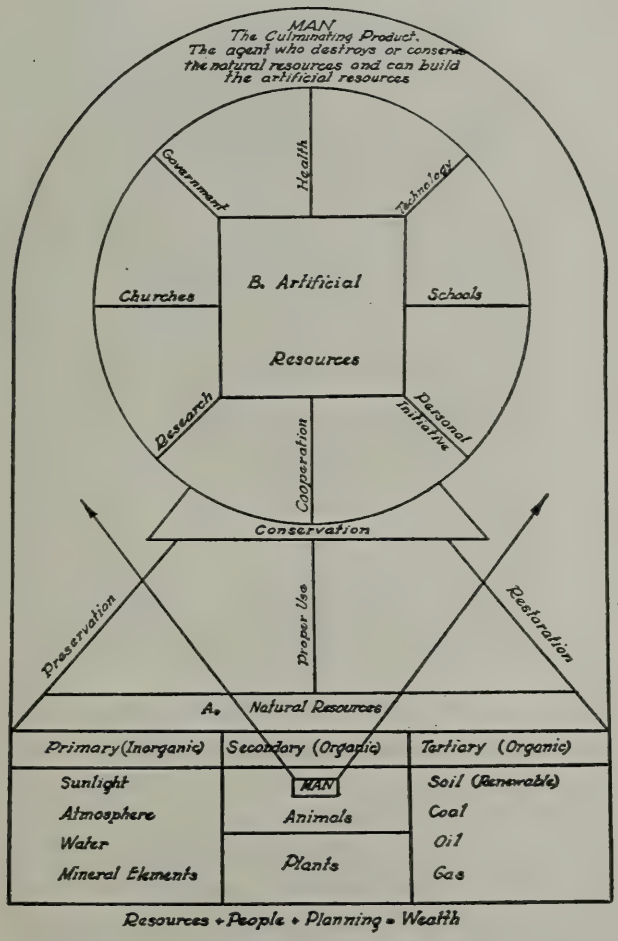
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over the fowl of the air, and over the cattle, and over all the earth, and over every creeping thing that creepeth over the earth. So God created man in his own image . . . . male and female created he them. And God blessed them, and God said unto them, Be fruitful and multiply, and replenish the earth, and subdue it; and have dominion over the fish of the sea, and over the fowl of the air, and over every living thing that moveth upon the earth. . . . . And God saw every thing that he had made, and behold it was very good. Thus the heavens and the earth were finished, and all the host of them."

Whatever your theories regarding the creation, the sequence as related in Genesis I is chronological and may be presented in chart form with subsequent additions to form a visual aid of great value in presenting the picture of the conservation and utilization of the natural resources in order to develop the artificial resources through which man exerts most of his energy in living.



The chart shows the natural arrangement of the primary and secondary resources and adds the tertiary, composed of these resources which developed through the interaction of the primary and secondary resources. Among these tertiary resources I placed soil at the top. There may be a question as to its chronological position but there is no doubt of its primary importance in the maintenance of life. To this subject I shall return presently.

The extractable resources—coal, oil, and gas—need no special comment other than they constitute a very important place in our present industrial era but they are by no means to be considered in a class with the primary and secondary resources. While these extractables constitute the basic resources of much of our present day wealth we shall learn all too soon I think that they can be rapidly depleted. Mankind, if it is to survive, must fall back upon the soil as the medium in which all food as well as all organic resources must be produced in order that life may continue indefinitely.

The chart also shows how through preservation, proper use and restoration, the keystone of conservation is laid to support the development of the artificial resources—those industries, businesses, and other occupations which man develops through his own creative efforts. The spokes in the wheel represent only a few of the channels through which man attains preparation for the adequate development of the artificial resources.

Enclosing this sphere is the area of man's influence. He is the culminating product; the agent who destroys or conserves the natural resources and can build the artificial resources.

We are in a position now to formulate the following fundamental concepts:

1. Survival is the basic goal of life.
2. The permanency of the State is measured by its ability to support indefinitely its share of the population on at least a level basis. This is the goal which every population must attain if it is to survive.
3. The maintenance of the population for an indefinite period is dependent primarily upon the conservation of the natural resources (sunlight, air, water, mineral elements, plants, animals, the soil, coal, oil and gas, which nature provided); and secondarily upon the development of the artificial resources (such as industries, businesses, commerce, and other undertakings which man develops through his own creative efforts in utilizing the natural resources).
4. No resource, natural or artificial is totally independent of other resources. There is a unity in all physical, chemical and biological phenomena.

Unless these concepts are followed, man will disappear from the earth. He has it within his power to conserve these resources and maintain his status indefinitely, or destroy these resources and in so doing destroy himself. We have traveled a considerable distance, altogether too far, along the latter road.

I have presented this picture of the natural

and artifical resources for the purpose of showing their relative position and importance in maintaining man on this earth for an indefinite period. It is very important that we keep this picture in mind. **Only through practicing conservation of the natural resources can man hope to survive!**

Coming back to the soil we find a resource which is renewable and almost wholly within the sphere of man's influence. If he would only realize the basic value of this resource—the medium in which is produced practically all of the food for man and animals—there would be less need for our worries today. It is apparent that man pays little attention to any resource as long as it is abundant. Only when he has depleted it to a point where its scarcity interferes with his economy does he begin to realize his folly. Even then he has little realization of what has happened. He notes that the soil is less deep; that it dries out quickly; that it cracks; and that it is less productive. But he fails to do any serious thinking about the causes of these conditions. He has not been aware of erosion; of the loss of organic matter; or of the depletion of the mineral elements. He is only discouraged and if he is the ambitious sort he abandons the farm and moves to newer land. If he is less ambitious he continues to live on less and less and eventually becomes a charity patient of the state.

This is the picture as many of us have seen it and passed by like the Pharisee. Scientists have given too little serious thought to these matters. We wait until some national calamity overtakes us such as war with its overwhelming demand for food; or we eventually find that overpopulation has caught up with us; or that some deficiency disease has increased to a point where realization is forced upon us.

Whatever the cause, whether from the gradual realization of the importance of conserving our resources, or from the lessons learned through the war years, we have come to a realization recently that there is a relation between the character of the soil and the people living thereupon. This observation has led some scientists to inquire into the causes of this condition. This concept is not new, of course, for we find evidence of it in the early literature of the world but with no general recognition until recently.

In the United States one of the early records which link soil composition to animal health was made by Owen in Kentucky in 1857 when he noted the vast difference in animal growth on the limestone soils as compared with animals on soils from the carboniferous rocks. Analysis of these soils showed fourteen times as much lime, three times as much phosphoric acid, and twice as much potash in the limestone soils than was present in the sandstone soils. The animals grazing on the limestone soils were described by Owen as being "almost a year in advance in bulk, weight, and form to the stock raised on the soils derived from the coal measures".

Within this 90-year period since Owen's observations there have been many similar observations made on both animals and humans. Bone deficiencies, teeth deficiencies, goiters, skin diseases, and other maladies have been noted and their relations studied and proved. The recent data on rejections of young men for military service have focused our attention on mineral deficiencies in certain areas, in particular the large number rejected because of bad teeth. This condition seems to be particularly evident in the carboniferous areas where the soils are notably deficient in calcium and phosphorus.

It will be worth while to look at the mineral composition of the human body and compare it with the minerals in our plant food and in our soils. The minerals in our animal foods are also of considerable importance, particularly milk. The composition of animal products with respect to minerals is reasonably uniform. This is in striking contrast to the condition in plants.

Percentage of Mineral Elements in Soils and Plants Essential to Man*

	Soils	Plants	Man
1. Calcium	1.02	8.44	42.24
2. Phosphorus ...	0.12	16.77	23.85
3. Sulphur	0.10	3.03	13.14
4. Potassium	3.02	52.85	8.34
5. Sodium	1.08	5.56	6.03
6. Chlorine	0.07	3.50	4.84
7. Magnesium ...	0.68	6.06	1.32
8. Iron	6.86	1.58	0.13
9. Manganese	0.12	tr	tr
10. Fluorine	0.06	tr	0.06
11. Copper			
12. Cobalt			
13. Zinc	0.26	0.16	0.05
14. Boron			
15. Iodine			
	13.39	97.95	100.0

*Data from Browne-USDA Yearbook 1938.

You will note that calcium is by far the most abundant mineral in the human body. This is also true of our domesticated animals. It requires more than 42 per cent of calcium to satisfy the mineral requirements of the animal body and this must be secured from the food consumed—from milk largely in the case of the young—from plants largely in later years; but

in either case it has to originate from the lime in the soil. It is remarkable that this large percentage of calcium in the animal body is derived from about one per cent in our average soil. Plants take this up and synthesize it in the plant body to build up an average of about 8.5 per cent of calcium. From this source and from the animal foods we consume, the large amount of calcium in the human body is formed.

It is readily deducted that any lime deficiency in the soil means a similar deficiency in the plant growing in that soil and results in a deficiency in the human body, where this element is of the greatest importance in building a strong and durable framework for health and longevity.

A similar situation exists with respect to phosphorus, the second most abundant mineral in the animal body. Analysis shows that nearly one-fourth of the ash of the human body is composed of phosphorus. Calcium and phosphorus combined constitute about two-thirds of the minerals in man. These two companion elements are closely associated and form a chemical union, calcium phosphate, which constitutes about 95 per cent of the inorganic bone material of the animal body.

We are just beginning to realize the importance of these two elements in the general health of ourselves as well as our livestock. As a matter of fact, we have given more attention to the health of our cattle, horses and other livestock than to ourselves, especially with reference to minerals in their feed.

For 50 years and more the importance of lime and phosphate has been emphasized by the Agricultural Experiment Stations for the adequate growth of farm crops, especially legumes. A large volume of literature is extant on this subject and farmers generally have been informed many times over of the necessity of liming and phosphating to maintain the fertility of their meadows and pastures. This practice gained much impetus with the initiation of the A.A.A. program in 1935, since when the use of lime and phosphorus has increased many fold, but still much of our lands, especially our hill pastures have never been treated with these elements.

While our average soil contains a very small amount of sulphur it is sufficient generally to supply the needs of plants and animals, largely in organic form. We have maintained a supply of this element through the use of sulphur containing fertilizers. Were this practice discontinued a sulphur deficiency would undoubtedly occur.

Potassium presents an unusual condition in that it constitutes over half of the mineral constituents of food plants while the animals consuming these plants need only about one-twelfth of their minerals as potassium. The real danger in potash hunger lies with the plant in its ability to secure it from the soil. Since relatively so much potash is used by plants it is essential that it be returned either in organic form or in mineral supplements; otherwise "potash hunger" is sure to appear in plants and sometimes in animals where this element is essential in the red cells.

It is of special interest to note sodium and chlorine, the two elements constituting the common table salt. Neither of these elements are abundant enough in the food of man and animals for normal health and since the time of man salt has been the chief condiment in his diet. Sodium chloride constitutes an important part of blood serum.

The other lesser elements, magnesium, iron, manganese and fluorine, are important. Magnesium is the essential element of the chlorophyll molecule without which we would not be able to produce our carbohydrates. Deficiencies of this element in the soil have been well recognized in tobaccos, potatoes and other crops.

Iron is an essential component of the hemoglobin. Without this constituent of red blood cells, the exygen we take in from the air can not be held and distributed. While iron is the most abundant element in the soil, essential to man, and is generally present, it is frequently unavailable through its association with calcareous and other soils of high alkalinity. Iron deficiencies in plants produce a distinct chlorosis which in some cases may be corrected by applying soluble iron salts in a spray.

Manganese deficiencies in both plants and animals are well recognized, producing types of chlorosis in plants and bone deformities in chickens.

Fluorine is perhaps not essential to plant or animals but seems to be invariably present and needs further study as to its role.

The minor elements, copper, cobalt, zinc, boron and iodine all have special functions. Like iron, copper is essential in building the hemoglobin of the blood. The lack of cobalt in pasture soils has resulted in definite cattle deficiencies in Florida. Important diseases of citrus, pecan, and tobacco are ascribed to zinc deficiencies. This may be corrected by spray applications. Boron has been studied extensively and many plant maladies have been attributed to a deficiency of this element in the soil. The application of borax to such soils has been shown to correct certain diseases of tobacco, sugar beets and celery. Care must be taken to regulate the dosage, because larger than necessary amounts may prove very injurious. One to five pounds per acre uniformly incorporated with a fertilizer is probably the most effective way of correcting boron deficient soils.

Iodine is well recognized as the essential element in the prevention of goiter. Certain soils

of sedimentary origin are deficient in iodine and have been recognized for years as goiter zones. Apparently this element may be incorporated with various soil amendments as well as with table salt with good results.

In this hasty review of the minerals in man essential to his health, I have mentioned only a few of the many relations which have been shown to exist with the soil. It may seem strange that these 15 particular elements constitute only about one-eighth of the mineral content of our crop soils. This is explained by calling to your attention that silicon constitutes 71.63 per cent of our average soils and aluminum 13.74 per cent. These two elements, which are non-essential in the animal body, constitute 85.37 per cent of the soil minerals. Small amounts of titanium, barium, and chromium make up the balance.

In any discussion of soil in relation to health one should not overlook that role which nitrogen plays in plant and animal nutrition. While this element is not a mineral its importance in relation to growth and health through the production of protein is of vital importance. We secure our proteins largely through the production of legumes which have that most unique ability of incorporating the nitrogen from the air in this process of synthesizing proteins in the plant. The legumes can accomplish this through the bacteria which form the nodules on their roots.

It is significant also that most legumes are heavy feeders on calcium and phosphorus. Our protein supply is therefore highly dependent upon these two essential minerals being present in adequate quantity in our crop and pasture soils for leguminous plant growth.

From the fact that nitrogen is so important for the production of protein—that nitrogenous material called the "stuff of life"—it is essential that full provision be made for all plant and animal needs. The amount which the legumes can "fix" from the air would be wholly inadequate. It must be supplied through other ways —especially important is the incorporation of organic material in our soils not only as a source of nitrogen for plant use but also as a water retaining agent. The use of artificial fertilizers containing nitrogen but especially barnyard manures are of the greatest importance. The fact that dairy farms in general are our most fertile farms lies in the better utilization of the minerals and organic wastes produced on these farms. It is believed that less plant food and therefore less animal food is lost on a well-managed dairy farm than on any other type of farm.

I have attempted to establish my thesis that there is a direct relationship between the soil and health in man through the food he consumes. It must be kept in mind constantly that the plants we grow are the great synthesizers of this food. If we supply them with an abundance of all their mineral requirements plus nitrogen and water and in addition if we use good judgment and practices in cooking and processing these foods so that the essential elements are not lost the health of our population would be increased enormously. I believe that our hospital, medical and institutional expenses could be greatly reduced through putting into practice the knowledge we already have at hand in building up our soils for the production of quality foods.

No discussion of health problems in these times can omit vitamins. Perhaps no modern development along nutritional lines has received more rapid public acceptance than the vitamin ideology of today. While their importance in many instances is unquestioned the ballyhoo given them by commercial interests is certainly out of all balance with their importance when compared with minerals in human and animal nutrition. Actually, if our foods contained adequate amounts of the necessary minerals for healthy bodies and we lived outdoors enough to get proper sunlight exposure and pay adequate attention to processing our foods we could forget about vitamins except in rare cases. In the words of Dr. Albright "The soil controls the body. Human deficiencies point the way back to the soil, not to the drugstore."

This leads me to suggest that if we are ever to get the importance of minerals in the soil impressed upon the public we must do something different than we have done in the past. We must have a new approach. It is really the manufacturers and retailers of vitamins who have sold this line to the public. If we would take a lesson from this successful endeavor we could sell the idea of minerals in the soil to the public through the processors and the retailers of foods. If the public learned for example that calcium, phosphorus, and nitrogen were absolutely essential to their health rather than that these were elements which the farmer needed just to grow alfalfa or clover, and if the processor and retailer advertised that their food products contained a guaranteed standard of these and other essential minerals then I believe progress toward better health would be realized. The scientist has done a good job in his field but he is not a salesman. We need health salesmen who will study the problem and sell health to the public through life giving elements in the soil. This is a field for study and action by the "Friends of the Land".

Prolonged malnutrition is a much more serious medical problem than famine, because it leads to diseases of low resistance, the chief of of which is tuberculosis, and to conditions which may take several generations to remedy.—Lord Horder, J.A.M.A., May 6, 1944.

Addison's Disease: Report of a Case and an Analysis of Autopsied Cases of Tuberculosis of the Adrenal Glands*

ROBERT P. HARDWIG, M.D., and CHARLES H. WRIGHT, M.D.

THE infrequency of Addison's disease in clinical practice is such that the Addisonian crisis may be overlooked. The following case is reported because it illustrates that source of error. The discussion covers an analysis of 78 cases of tuberculosis of the adrenals disclosed by autopsy.

REPORT OF A CASE

A white male 25 years of age was admitted to Lowman Memorial Pavilion, the tuberculosis division of Cleveland City Hospital, on May 14, 1945. In the autumn of 1943, pulmonary tuberculosis of questionable activity was discovered in an industrial survey conducted at the defense plant where the patient had worked as a metallurgical engineer for the preceding 3½ years. He was re-examined in the Health Department Clinic about 4 months later and, in the words of the patient, there was "no progression". He failed to report to the clinic thereafter.

On April 21, 1945, he was suddenly taken ill with malaise, weakness, general loss of strength and shortness of breath. He had an episode of diarrhea of 3 days' duration. His chronic cough and morning expectoration of 1 to 2 drams remained unchanged. His weakness and loss of strength were progressive. On the basis of a chest film and the finding of acid-fast bacilli in the sputum, a diagnosis of pulmonary tuberculosis was made and he was admitted to City Hospital. There was an indefinite history of a 20 pound weight loss in the 3 weeks preceding admission.

Past history revealed that he had had acute anterior poliomyelitis at the age of 1 year, resulting in partial disability of the left lower extremity. There had been slight shortness of breath on exertion and slightly limited activity, occasioned by easy fatigability, all his life. He had also noted cyanosis of lips and nail beds in cold weather and on marked exertion. Otherwise the systemic review was not significant. The family and social histories were irrelevant.

Physical Examination. The temperature on admission was 37.5° C., the pulse rate 90, respiratory rate 21 and the blood pressure 100/60. The patient was a thin, poorly nourished asthenic white male who appeared chronically ill. The skin was generally of a dark brown hue with no selective areas of hyperpigmentation. The lips were slightly cyanotic. No abnormalities of the mucous membranes were noted. The thorax was flat-chested but symmetrical. The back was rounded but no kyphosis was noted. The heart was not enlarged, the rhythm was normal, and no thrills or murmurs were present. The abdomen and genitalia were negative. There was no significant lymphadenopathy. There was marked atrophy of all muscles of the left lower extremity with a marked pes cavus deformity of the foot. There was definite and marked clubbing of the fingers and slight cyanosis of the nail beds.

Laboratory Work. The cell volume was 42.2. The corrected sedimentation rate by the Wintrobe method was 1.44. The vital capacity was 2700 cc., or 63 per cent of normal. Urinalysis showed an acid reaction and a specific gravity of 1.018; albumin, sugar and benzidine tests were negative; microscopically only occasional white cells were seen. Sputum examinations on the three successive days following admission gave Gaffky counts of 3, 5 and 6 respectively.

X-Ray Report: The films were read at a staff conference by Dr. R. C. McKay whose interpretation is quoted: "There are two films made on Feb. 1, 1944, both of which show fine diffuse mottling distributed throughout both lung fields. The distribution is roughly symmetrical but is rather irregular and not entirely characteristic of hematogenous dissemination. There is also effusion between the right diaphragm and the chest wall. The latest film is dated June 1, 1945. It shows a residue of the previously described diffuse mottling plus a well defined 1.5 x 2 cm. cavity in the left apex. This is confirmed by a positive sputum. The clinical diagnosis, therefore, is pulmonary tuberculosis, far advanced."

The patient's hospital course was uneventful until 4 days before death, at which time he complained of nausea and vomited twice. He also had a vague mild pain in the region of the umbilicus. Bowel habits had been normal. The abdomen was soft, there was slight umbilical tenderness with no rebound tenderness, there was no distention or fluid, and the abdomen was quiet to auscultation. Temperature, pulse and respirations were normal. The next day the patient said he felt much better. The following day, this being the day before death, he said he felt "perfectly all right". Examination of the abdomen at this time was again negative. On the day of death the temperature fell to 35° C. and the slight cyanosis which had been present since admission was further slightly increased. He felt sleepy and was extremely indifferent to questioning. A short time later there was marked cyanosis; he became short of breath and dyspneic. Lethargy and mental cloudiness were suddenly prominent. The neck was not stiff and Kernig and Brudzinski signs were absent. Examination of the chest showed no evidence of a spontaneous pneumothorax. The cardiac rhythm was regular, with a slight tachycardia but no murmurs. Examination of the abdomen was negative. The reflexes were generally hypoactive. Immediately after this examination was completed the pulse became rapid, weak and then was not palpable at all. Concomitantly the blood pressure fell to 20/0 and then became unobtainable. A lumbar puncture yielded 8 cc. of clear cerebrospinal fluid under a pressure of 2 mm. of mercury. The Pandy test was negative and there were 4 mononuclear cells per cu. mm. An intravenous infusion of normal saline was

From the Department of Pathology, Cleveland City Hospital, Cleveland, Ohio.

*Selected by H. T. Karsner, M.D., from the Clinico-Pathological Conferences at Cleveland City Hospital as the thirtieth of a series of cases to be published under the heading "Case Records Presenting Clinical Problems".

begun. He rapidly became moribund and developed respiratory failure which did not respond to coramine. Artificial respiration was ineffective and the patient died approximately 3 hours after the beginning of the acute episode on the 18th hospital day.

Autopsy (A-15855) was performed 18½ hours after death. The body was that of a well developed but poorly nourished, 25 year old white male with an estimated weight of 59 kg. Clubbing was marked in the fingers and slight in the toes, and except for cyanosis of the nail beds no discolorations were noted over the body. The left leg and thigh were about two-thirds the size of the right, with a pes cavus deformity of the foot.

Both pleural cavities were obliterated by dense fibrous adhesions. The pleura overlying the left apex was thickest measuring 0.5 cm. The consistency of both lungs was increased. On section there was found in the left apex an irregular cavity measuring 2 x 1 cm. filled with caseous material and surrounded by a zone of fibrosis. Anterior to this cavity in the upper part of the lower lobe were light gray areas of caseation measuring up to 4 mm. in diameter. Both lungs showed saccular dilatations of the bronchioles with fibrosis of the surrounding parenchyma.

The right adrenal weighed 25 gm. and measured 7 x 3.5 x 2.5 cm., while the left weighed 35 gm. and measured 8 x 4 x 2 cm. The right adrenal was adherent to the inferior surface of the right lobe of the liver. The adrenal glands were nodular, firm and light grayish-yellow. The cross sections presented conglomerate masses of grayish-yellow caseous material with focal areas of calcification. Adrenal tissue could not be identified. There was also local extension of the caseous material into the right inferior lobe of the liver at its junction with the adrenal gland.

The posterior cortical surface of each kidney showed a pale yellow caseous mass which measured 2 mm. on the right and 1 mm. in diameter on the left.

The peribronchial, left bronchopulmonary and peripancreatic lymph nodes showed massive caseation with only small amounts of lymphoid tissue remaining.

The spleen was not remarkable grossly.

Microscopic Examination. The lungs showed chronic ulcerative tuberculosis of the left upper lobe. Active conglomerate and miliary tuberculosis was most advanced in the left upper lobe but were present in all lobes. Fibrosis was diffuse and also conspicuous around the tubercles. There was pronounced chronic bronchitis and bronchiolitis.

The adrenals contained only a few tiny foci of degenerated but recognizable cortical cells. The adrenal tissue had been largely replaced by conglomerate areas of caseation with focal areas of calcification. Active tubercles were seen in several spots but the chief reaction was one of caseation with fibrous proliferation. The arterioles showed proliferative endarteritis.

Both kidneys, the liver and the peripancreatic and bronchoplumonary lymph nodes showed multiple foci of active fibrocaseous tuberculosis similar to that seen in the lungs and adrenals. The spleen showed multiple active miliary tubercles.

The final anatomical diagnoses were: Chronic ulcerative tuberculosis of upper lobe of left lung with subacute bronchogenic spread to all lobes; conglomerate fibrocaseous tuberculosis of adrenals with focal calcification; fibrocaseous tuberculosis of kidneys, liver and peripancreatic and bronchopulmonary lymph nodes; and acute miliary tuberculosis of spleen.

DISCUSSION, AND ANALYSIS OF 78 CASES OF TUBERCULOSIS OF ADRENAL

In retrospect this patient presented 5 cardinal signs and symptoms of Addison's disease; namely, asthenia, gastrointestinal complaints, hyperpigmentation, hypotension and loss of weight. Unfortunately, these facts were not so apparent at the time as their presentation here would make it appear. While weakness had been notable, it was not a prominent symptom on admission or during his hospital stay. His gastrointestinal complaints were not marked and could be duplicated many times over by other patients in the department. His blood pressure on admission, too, was not unusual among tuberculosis patients. Hyperpigmentation was present, but it was slight in degree, presented no selective distribution and was not much out of the ordinary for a person with a naturally dark complexion. Presenting over such a period of time this chain of symptoms and signs was not pieced together until after the autopsy.

In short, this was a 25 year old male in fairly good health who quite suddenly presented a picture of mental lethargy rapidly progressing to coma, dyspnea, cyanosis and shock. He was seen by at least three different members of the staff and the consensus was that this represented some type of intracranial lesion, the exact nature of which was not clear. Tuberculous meningitis and ruptured congenital aneurysm at the base of the brain were ruled out by a lumbar puncture. Tuberculoma was considered but was hardly a satisfying explanation. A cerebral embolus from the left side of the heart was considered in view of the history suggestive of a congenital heart lesion; i.e., shortness of breath on exertion, limited activity, clubbing of the finger nails and cyanosis. This was hardly tenable in view of the complete absence of any physical signs indicating a cardiac lesion. Spontaneous pneumothorax, a remote possibility, was neither consistent with the general clinical picture nor with the physical signs. There was no satisfactory explanation of the patient's condition. In retrospect, his lethargy and coma were undoubtedly due to cerebral anoxia secondary to the circulatory collapse rather than the lethargy, coma and shock all being due to some primary intracranial process. Hypoglycemia secondary to adrenal failure may also have been contributory.

The circumstances of this patient's death raised questions of the incidence of Addison's disease in autopsied cases in general as compared with its incidence in cases which had been under treatment for pulmonary tuberculosis and, more

specifically, the frequency with which the clinical diagnosis may have been overlooked. Accordingly the autopsy protocols of all cases in which a pathologic diagnosis of tuberculosis of the adrenals had been made were examined. During the period from Feb. 1, 1935, to October 1, 1943 (9 years and 8 months), 78 such cases were found.

Of the 78 cases, 47 were from the tuberculosis department. During this interval there were 567 postmortem examinations conducted on patients from this department, making the incidence of tuberculosis of the adrenals in this group 8.3 per cent (Table I). During the same period of time 5,217 autopsies were performed, including cases from the entire hospital. The over-all incidence of tuberculosis of the adrenals in this autopsy series is thus 1.48 per cent.

Concerning extent and type of the lesions found in the adrenals, 31 of the cases had involvement of but a single adrenal. The remaining 47 cases showed bilateral adrenal lesions. Twenty-five of these 47 showed only miliary tubercles varying in size from those seen only microscopically to those 1 to 2 mm. in diameter. The remaining 22 of the 47 cases with bilateral involvement showed conglomerate caseous tuberculosis of the adrenals. In 19 of these 22 cases the most extensive involvement (save in a case presented below) was demonstrated in a male who, after gross and microscopic study, was found to have about 60 per cent of the right adrenal entirely replaced and an 8 mm. nodule in the left. The clinical chart of this patient was reviewed and he presented no symptoms or signs of adrenal insufficiency.

The remaining 3 cases showed practically complete replacement of adrenal tissue by conglomerate caseous tuberculosis both grossly and microscopically and will be presented briefly. The first, a male, was admitted to the medical service complaining of weakness of one year, inability to walk for 3 weeks, shortness of breath on exertion, weight loss of 30 lb. and "darkening" of the skin of the hands and face over a period of 4 years. There was persistent hypotension, elevated blood urea nitrogen and nonprotein nitrogen, hypoglycemia and consistently low blood chlorides. A diagnosis of Addison's disease was made and pulmonary tuberculosis was also demonstrated by X-ray. Despite therapy with saline and desoxycorticosterone acetate, he died on his 171st hospital day.

The second patient, a woman, was admitted to the tuberculosis department with complaints of a "sore mouth" of 6 months' duration, unusual weakness and malaise, weight loss of 30 lb., cough with expectoration of 2 to 3 drams of mucopurulent sputum daily, and pleuritic pain in the left chest for 1 week. Her mouth lesions were refractory to treatment and a biopsy proved them to be tuberculous. During her hospital stay exaggerated weakness was prominent. She complained of nausea and vomiting, which began 5 days before death and persisted. The day before death her blood pressure was unobtainable and skin pigmentation was noted. The clinical features and chemical examinations justified the diagnosis of Addison's disease. Treatment with saline infusions began, but she died suddenly on the following day after approximately 2 months' hospital stay.

The third patient, a white male, was admitted to the surgical service in a moribund state, comatose and in shock. History from the wife revealed that 3 years previously he had had a left nephrectomy for tuberculosis of the kidney. Frequency and dysuria persisted but his general condition remained good. Two weeks before admission there was a gradual and progressive onset of nausea, vomiting and marked weakness. The day before admission he complained of abdominal pain. On admission, the abdomen was tender and rigid, the skin pigmented a bronze tinge, the blood pressure unobtainable and there were beaded nodules in the epididymes. The blood urea nitrogen was slightly elevated. The patient died after 10 hours in the hospital.

The terminal picture of two of these cases is similar to that of the subject of this report. Attention in all of these cases is especially focused on the pigmentation, hypotension at shock levels, coma and abdominal symptoms, the latter being striking enough in one case to warrant admission to the surgical service as a case of acute abdominal disease. In 2 of these cases the clinical diagnosis of Addison's disease was made unequivocally; in the third it was a working diagnosis and would undoubtedly have been the final diagnosis had not death supervened within 10 hours. The importance of acute infection in precipitating crisis is indicated by the eleventh case of the "Series of Case Reports Presenting Clinical Problems" (Laipply, T. C., O.S.M.J., 38:845-846, 1942).

In addition to these 3 cases of Addison's disease in which tuberculosis of the adrenal glands was the etiologic factor, one case was found in this autopsy series in which atrophy and cytotoxic degeneration of the adrenals were responsible for the clinical picture of Addison's disease. This man had been placed on a salt-free diet in an attempt to precipitate a crisis in order to establish the diagnosis. He relapsed suddenly and died before therapy could be instituted. This case emphasizes first, the acuteness with which crises may supervene, constituting a true emergency; and second, the danger of attempting to initiate a crisis by placing the patient on a salt-free diet.*

*Garvin, C. F., and Reichle, H. S.: Death Presumably due to the Use of the Salt Restriction Test in the Diagnosis of Addison's Disease. Ann. Int. Med., 14:323-324, 1940.

The total of 4 cases of Addison's disease makes an autopsy incidence of 0.08 per cent (Table I). Two of the patients were from the tuberculosis department, making the incidence of Addison's disease in 567 autopsied patients who had been under treatment for pulmonary tuberculosis 0.4 per cent.

The question of whether or not the clinical diagnosis of Addison's disease was overlooked in any of the cases in this series is debatable. A 36 year old white male was under treatment at this and other hospitals for chronic pulmonary tuberculosis, tuberculosis of the right and left shoulders and tuberculosis of the spine over a period of 2 years. There were no symptoms suggestive of Addison's disease. He had hyptotension (95/60) but there were no other signs compatible with a diagnosis of Addison's disease, and his manner of death excited no suspicion of Addisonian crisis. At autopsy bilateral conglomerate tuberculosis of the adrenals was found with "complete macroscopic and nearly complete microscopic destruction of each adrenal". In view of these observations an Addisonian syndrome would be expected as highly probable. However, the estimation of premortem functional capacity on the basis of portmortem structural features is fraught with much uncertainty. It can hardly be said that this was a case of Addison's disease, particularly in view of the fact that there were absolutely no clinical signs or symptoms save hypotension to substantiate such a diagnosis.

Information relative to the presence of tuberculosis in other organs in connection with tuberculosis of the adrenals was also obtained (Table II). Seventy-four of the 78 cases had associated active tuberculosis elsewhere. There was chronic pulmonary tuberculosis in 18 cases, and chronic pulmonary tuberculosis associated with a terminal miliary spread in 20 cases, or a total of 38 cases with active chronic pulmonary disease; disseminated acute miliary tuberculosis in 20 cases; and focal extrapulmonary lesions in 16 cases. In 1 case only obsolete inactive foci in the liver and spleen were found, with no other sites of tuberculosis.

In 3 cases autopsy failed to reveal any tuberculosis process anywhere except in the adrenals. In these 3 cases tuberculosis of the adrenal was an incidental observation at autopsy, the cause of death being hypertensive cardiovascular disease with hemorrhage into the thalamus, lobar pneumonia and lymphosarcoma respectively. That the failure to demonstrate other tuberculous foci in these 3 cases may have been due to inadequate search is plausible. The case with obsolete lesions in the liver and spleen was similar to the other 3, the cause of death being carcinoma of the bladder. The three cases of Addison's disease due to tuberculosis of the adrenals were associated with active tuberculosis elsewhere; two cases had chronic ulcerative pulmonary tuberculosis and the third was associated with active lesions in the epididymes.

SUMMARY

A case of Addisonian crisis presenting an acute terminal picture of shock and coma has been reported. A patient presenting such a picture should have a careful history taken and physical examination performed in a search for other evidence pointing toward Addison's disease. Even though infrequent, the possibility must be thought of, particularly in patients with known tuberculosis elsewhere.

Tables I and II give the analysis of 78 cases in which autopsy disclosed tuberculosis of the adrenals. The incidence is greater among tuberculous patients than among the general hospital population. Conglomerate caseous tuberculosis of both adrenals was found in only 22 instances and of these only 3 gave clinical evidence of Addison's disease.

TABLE I

Incidence of Tuberculosis of Adrenals and Addison's Disease In an Autopsy Series (Feb. 1, 1935, to Oct. 1, 1943)

	Total Number of Autopsies	Tuberculous Adrenals		Addison's Disease	
		No.	Per Cent	No.	Per Cent
Entire Hospital	5217	78	1.48	4*	0.08
Tuberc. Dept.	567	47	8.3	2	0.4

*3 (0.06 per cent) due to tuberculosis.
1 (0.02 per cent) due to cytotoxic atrophy.

TABLE II

Other Organs in Association With Tuberculosis Of Adrenals

I. Active Tuberculosis		
(a) Chronic Ulcerative Pulmonary		
1. Without Spread	18	
2. With Terminal Miliary Spread	20	
Total		38
(b) Acute Miliary Tuberculosis		20
(c) Focal Tuberculosis, Extra Pulmonary		16
Total		74
II. Inactive Tuberculosis		
(a) Obsolete Foci in Liver and Spleen		1
III. No Other Tuberculosis		3
Total		78

Tuberculosis Abstract

A Review for Physicians Issued by the National Tuberculosis Association and Distributed by Component Society, the Ohio Public Health Association

CHEMOTHERAPY IN TUBERCULOSIS

IN 1939 and 1940 the sulfonamide drugs were shown to have some retarding effect on the rate of development of tuberculosis of guinea pigs, but in no instance did the drugs actually arrest the disease.

The drugs of the sulfone series (promin, diasone and promizole) were the first preparations to succeed in actually arresting tuberculosis in the highly susceptible guinea pig. This led to high hopes that sulfone drugs might be of value in the treatment of human tuberculosis. Several hundred tuberculosis patients have now received treatment with these drugs. Experience has tempered the early enthusiastic hopes of some physicians.

Most sulfone drugs, unfortunately, have a much more toxic effect on human beings than on guinea pigs. It is suspected that some sulfone drugs are altered in the human body and become ineffective. The possibility that sulfone drugs may be of aid in treatment of certain unusual varieties of human tuberculosis has not been excluded, but no definite place has been found for these drugs in treatment of the usual types of tuberculosis. The use of sulfone drugs under any circumstances has not progressed beyond the experimental stages.

The only sulfone drug which has been approved by the Federal Drugs Administration for sale is promin. This is available in jelly form for application on the surface of external tuberculous lesions. The effectiveness of promin has not been completely established even for this special use.

The amazing success of penicillin in treatment of several infectious diseases again aroused hopes that this or a similar antibiotic substance might be developed which would be effective against tuberculosis. Penicillin itself appears to have no effect on tuberculosis in guinea pigs or in man, but many other substances may be extracted from living micro-organisms which can suppress the growth of bacteria which produce disease.

Of these only streptothricin and streptomycin need now be considered. Streptothricin and streptomycin are both derived from soil-inhabiting fungi (*Actinomyces lavendulae* and *Actinomyces griseus*). Both restrain the growth of tubercle bacilli in the test tube. Streptothricin is somewhat toxic to guinea pigs and does not restrain the development of tuberculosis in these animals.

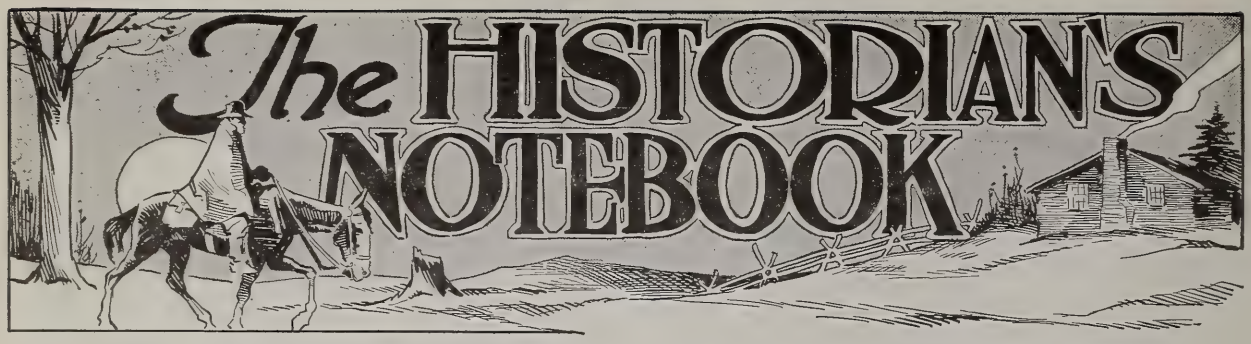
Streptomycin is well tolerated by guinea pigs, and extensive investigation has shown that it does inhibit in them the growth of experimental tuberculosis. In a third of the guinea pigs treated streptomycin apparently will eradicate advanced tuberculosis. In the other two thirds treatment with streptomycin will bring the disease to a stage that can be regarded as arrested.

Adequate study of streptomycin in treatment of human tuberculosis remains to be done. Certain obstacles lie in the path of further progress along this line.

The distribution of new drugs for the necessary preliminary, laboratory and clinical trials is entirely in the hands of the manufacturers. Investigators receiving drugs for this purpose must have proper facilities to carry out the contemplated research accurately and safely. They also may be called on to account for all of the drug supplied and to submit complete reports of their researches which eventually are forwarded to the Federal Security Agency. Obviously, it is impossible for research workers to share their supplies of new drugs before the necessary research is completed.

The channels through which information about new scientific developments flows are direct and dependable. When a research worker has completed a project, he submits a report to the editors of one of the many medical and scientific journals, and usually publication of the results of his work follows within a few months. This enables other research workers and physicians to utilize promptly any of these new facts either in treatment of patients or in the development of new scientific information. The prompt publication of results is an ethical responsibility of the scientist to aid others engaged in similar problems. No one need fear that he will be denied any valuable secret remedy.

Newspaper reporters and authors of magazine articles recognize the news value of scientific discoveries. Occasionally they use sources of information less authoritative than those of established medical journals, to the chagrin of research workers and to the confusion of patients. Human lives may be lost needlessly if patients who have tuberculosis choose to forsake or refuse well-established methods of treatment in the hope of receiving remedies inadequately tried or of unproved effectiveness.—Chemotherapy in Tuberculosis, H. C. Hinshaw, M. D., and William H. Feldman, D. V. M., The NTA Bulletin, Oct. 1945.



Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio

Cholera Infantum

JONATHAN FORMAN, B.A., M.D., F.A.C.A.

IN collecting medical books with an Ohio imprint, I recently acquired a copy of "An Essay On Cholera Infantum by Moses L. Knapp, M. D., published by H. W. Derby in Cincinnati, Ohio, 1855."

Dr. Moses L. Knapp (1799-1879) was a member of the first class graduated at Jefferson Medical College (1826) and his thesis was the first to be published by Jefferson. We find him teaching for a few terms at the short-lived Medical Department of Laporte University in Indiana. Next we find him in 1843 on the first faculty of Rush Medical College as Professor of Midwifery and Diseases of Children.

The Rock Island Medical School was organized in 1848 as a branch of Madison Medical College, a Wisconsin institution, with a provision in its charter which allowed it to create branches elsewhere than in Madison. In fact, it seems the Rock Island School was its only activity. It seems clear now that this was only a plan to get a charter under which to get legal medical degrees. On the first faculty of the Rock Island School was Moses L. Knapp as Professor of Materia Medica and Therapeutics.

At the time he wrote this interesting pamphlet (1855) he had recently resigned from the chair of Materia Medica and as President of the College of Physicians and Surgeons of the University of Iowa.

The blurb on the inside cover carries praise from William P. C. Barton, M. D., and Alfred Stille, M. D. They seem to agree with the author who set forth the thesis that:

> "Cholera Infantum differs in nothing that is essential in its nature or pathognomonic in its character, from Asiatic or Epidemic Cholera in adults; or in other words, that the hitherto supposed two forms of disease are one and the same, produced by the same cause or causes, the phenomena differing somewhat on account of age, and I furthermore hold, that the disease is essentially a scorbutic affection."

To support this thesis, he marshalled the evidence derived from (1) history, (2) from the phenomena, and (3) from therapeutics. Dr. Knapp published a five-page chart showing side by side similarities in symptoms, course, anatomical characteristics, and pathology of the blood of all three diseases.

Scurvy was a common disease in those days. For instance, of 788 soldiers at Fort Calhoun on the Missouri River in January 1820, nearly 500 suffered from scurvy and 157 died. The use of fresh fruit against scurvy was purely an empiric procedure and was finally recognized to be paralleled by that of a number of other food elements in preventing various pathological developments.

> "The scurvy was notoriously inland and manifest all over the western country last spring, and the past summer and autumn have a more wide-spread epidemic of the ague and fever character than has been seen probably since 1835, after the great blight in vegetation and scarcity of succulent vegetable food of the preceding year."
>
> "My own convinctions are, that if all breeding and nursing women could have plenty and a variety of good animal and vegetable food;

The Author

● **Dr. Forman, Columbus, Ohio, is Professor of the History of Medicine in the College of Medicine in the Ohio State University and Chairman of the Committee on Medical History and Archives of the Ohio Archeological and Historical Society.**

were enjoined to indulge in the free use of oranges, lemons, apples, and all kinds of fruits . . . . . and infants at the breast were allowed, in addition to the rich vegetable milk emulsion which such a dietary on the part of the mother would afford them, to suck oranges and roasted apples and to have lemonade . . . . . as freely as their pantomime inclinations seem to demand . . . . . cholera infantum would be nearly banished from the catalogue of human diseases."

Sounds pretty modern, doesn't it?

Cholera Infantum is not infrequently attendent with disposition to collapse like that which occurs in cholera of the adults. In fact, our author recognizes these things, the latent condition and collapsing tendency, vomiting, februle paroxysms, purging and all the other data only served to emphasize in his mind the identical character of these three diseases.

* * * * *

We have only hinted here at the contents of the 95 pages of this pamphlet which teaches us a valuable lesson. That is, in our attempt to generalize and simplify our observations we may easily overshoot the mark. Shryock has shown that every one of our cults, homeopathy, Thomasonian, reformed botanics, electricsism, osteopathy, chiropractic, nprapathy, and even Freudism within our own household (?)—all have one cause, one master, and one book. That is the formula which leads even good minds astray. The truth is always simple, but we can not simplify safely until we have all of the facts. No where in modern medicine is this better illustrated than by the Unitarians among the allergists of this country today.

Truman Names Medical Committee

President Truman has appointed a nine-member committee to coordinate governmental medical services. Its first major task, a White House statement said, "is to find ways of increasing the medical facilities of the Veterans Administration".

The members are: Dr. Harold W. Dodds, president of Princeton University; Dr. Frank H. Lahey, of the Lahey Clinic, Boston; Dr. Basil C. MacLean, Rochester, N. Y., formerly of the Army Medical Corps; Col. Howard Rusk, M. C., formerly of the Army Air Forces, now conducting a department of veterans rehabilitation for the *New York Times;* Dr. Charles W. Mayo of the Mayo Clinic, Rochester, Minn.; Maj. Gen. Howard McC. Snyder, U.S. Army; Rear Admiral Daniel Hunt, U. S. Navy; Dr. Thomas Parran, surgeon general, U. S. Public Health Service; Chester I. Bernard, Newark, president, New Jersey Bell Telephone Co.

Revised E. M. I. C. Plan Grants Higher Fees To Board Diplomates

The Ohio Department of Health has been advised by the U. S. Children's Bureau that it has approved an amendment to the Ohio Emergency Maternity and Infant Care Plan, permitting Ohio to pay physicians certified by the Board of Pediatrics and by the Board of Obstetrics and Gynecology a 50 per cent higher rate for medical services.

Under the revised plan, a physician certified by the American Board of Obstetrics and Gynecology will be paid for maternity care at a rate not to exceed $75.00 for complete care. This maximum payment of $75.00 will be provided as follows: A maximum of $22.50 for prenatal care at $3.00 per office or hospital visit and $4.50 per home visit; $45.00 for delivery; and $7.50 for the postpartum examination six weeks after delivery.

When fewer than five prenatal examinations are made, when no postpartum examination is made, or when other services recognized as part of routine complete maternity care are omitted, the rate of payment for complete maternity care is to be adjusted to cover only the services actually rendered.

Payment for care of an infant by a physician certified by the Board of Pediatrics will be paid at a rate not to exceed $36.00 for the first three weeks of illness and for succeeding weeks of illness not to exceed $9.00 per week. The maximum rate of payment for a home visit and examination or treatment not to exceed $4.50 and for an office or hospital visit for examination or treatment not to exceed $3.00.

This new rate of payment became effective January 1, 1946.

Physicians who are diplomates of either board should so state on the application blank requesting approval of services so the new fees can be applied to his services.

Wallet-Size Birth Certificate

The State Department of Health is now prepared to furnish a wallet-size, fraud-proof certification of all births registered with the Division of Vital Statistics. The certifications are 2½" by 3½", about the same size as an identification card. They are enclosed in a transparent thermoplastic casing. The name, birth date, place of birth, color and sex are typewritten on the cards, which are printed on a special paper watermarked with the Great Seal of the State of Ohio. Requests for the certification should be addressed to the Division of Vital Statistics, State Department of Health, State Office Bldg., Columbus. The cost is 25 cents.

Make Your Hotel Reservation Immediately for Centennial Anniversary Meeting of State Association, May 7-9

IT isn't too early to make your request for hotel reservations for the Centennial Anniversary Meeting of the Ohio State Medical Association, Tuesday, Wednesday and Thursday, May 7, 8 and 9, at the Neil House and the Deshler-Wallick Hotel, Columbus.

Celebrating 100 years of medical progress in Ohio, this will undoubtedly be one of the greatest State Meetings in the Association's history. Plans are already well along for a top-notch program.

In order to insure obtaining the type of accommodations you will require, make a request for reservations—**immediately**—to the hotel of your choice. Look over the accompanying list of Columbus hotels and address your request on the attached blank to the management of the hotel selected.

NAME AND LOCATION	No. of Rooms	Single	Double	Double Twin Beds	Suites
NEIL HOUSE 35 South High St.	665	$4.40-7.70	$5.00-9.00	$5.50-11.00	Rates on request
DESHLER-WALLICK Broad and High Sts.	1000	3.30-8.80	5.50-11.00	5.50-13.20	Rates on request
FORT HAYES 31 W. Spring St.	350	3.00 and up	4.50 and up	5.00 and up	7.00-20.00
CHITTENDEN High and Spring Sts.	275	2.00-3.00	3.00-4.00	3.50-6.00	
SENECA 361 E. Broad St.	250	2.50-4.00	4.00-5.00	5.00-6.00	8.00-12.00
SOUTHERN High and Main Sts.	250	2.50-3.00	3.50-4.00	4.00-4.50	
VIRGINIA Third and Gay Sts.	150	2.20 and up	3.30 and up	4.40 and up	
BROAD-LINCOLN 631 E. Broad St.	140	2.20 and up	3.30 and up	4.95 and up	3.85 and up

HOTEL RESERVATION BLANK

Mail this coupon to hotel selected

Manager _____ Hotel, Columbus, Ohio.

You are requested to reserve the following accommodations during the period of the Centennial Anniversary Meeting of the Ohio State Medical Association, May 7, 8 and 9, 1946, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double room with bath Price: _____

☐ Twin Bed Room with bath ☐ Suite

Arriving May _____ at _____ A. M. _____ P. M.

PLEASE VERIFY MY RESERVATION.

Name _____

Address _____

_____

Proceedings of The Council

Action Taken at December 15 Meeting for Expansion of Activities of State Association; Statement on Health Program for Ohio To Be Drafted; Budget Approved

A REGULAR meeting of The Council of the Ohio State Medical Association was held in the State Headquarters Office, Columbus, on Sunday, December 16, 1945. The following Officers and Councilors were in attendance: President Schriver, President-Elect McNamee, Past-President Sherburne, Treasurer Mitchell; Councilors Swartz, Messenger, Noble, Brindley, Dixon, Rutledge, Lincke and Harding; Dr. Forman, Editor of *The Journal;* Executive Secretary Nelson and Assistant Executive Secretary Saville. Also in attendance were the following Ohio delegates to the recent annual session in Chicago of the House of Delegates of the American Medical Association: Dr. Harry V. Paryzek, Cleveland; Dr. Carl R. Steinke, Akron; Dr. B. J. Hein, Toledo; Dr. Wm. M. Skipp, Youngstown; and Dr. H. M. Platter, Columbus.

In opening the meeting President Schriver referred to the successful conference of county society presidents, secretaries and committeemen, held in Columbus on November 11. He stressed the necessity for additional activity in county medical societies and urged all members of The Council to keep in close touch with the societies in their district and to visit them as often as possible.

On **motion** by Dr. Brindley, seconded by Dr. Dixon, and **carried,** the minutes of the last meeting of The Council held on August 19, 1945, **were approved.**

The Executive Secretary presented a report on the membership of the State Association. The report showed that as of December 15, 1945, the total membership of the Association was 6,905, of which 1,995 were military members. The total membership of the Association as of December 31, 1944, was 6,878.

On **motion** by Dr. Noble, seconded by Dr. Swartz, and **carried,** The Council decided that the policy of the Association providing for waiver of State Association dues for men in military service, which policy has been in effect since the outbreak of the war, should be continued throughout the calendar year 1946.

FEDERAL LEGISLATION

There was a general discussion of the proposed national health program of President Truman; Senate Bill 1606, introduced by Senators Wagner and Murray, and House Resolution 4730, introduced by Congressman Dingell, proposing to activate the Truman program; and the so-called Pepper maternal and child health bill, S. 1318. Action taken by the House of Delegates of the American Medical Association on these matters also was considered.

On **motion** by Dr. Lincke, seconded by Dr. Dixon, and **carried,** The Council voted to actively oppose the three proposals mentioned above in their present form, believing that the enactment of these measures in their present form would result in the lowering of medical standards and the quality of medical services and would result in gigantic systems of politically and bureaucractically controlled medical and health care.

In the same motion, the Executive Secretary was instructed to prepare concise digests of these three proposals and a digest of the Hill-Burton proposal, S. 191, the so-called hospital construction measure which has the approval of The Council, for distribution to members of the State Association.

Also in the same motion The Council instructed the Committee on Public Relations, in cooperation with the headquarters staff of the State Association, to prepare a platform for the Ohio State Medical Association, setting forth the policies of the Association and enumerating specific plans and recommendations of the Association for coping with the problem of improving existing health and medical services and facilities in Ohio. The purpose of such a statement would be to outline what is being done in this state by the medical profession and other agencies and organizations, or contemplated, and how these activities could be coordinated into a general over-all health program for this state and carried on with a minimum of assistance from the Federal Government.

REPORT OF A. M. A. DELEGATES

At this point Dr. Schriver introduced the Ohio Delegates to the American Medical Association present at the meeting and at his request each delegate made a report to The Council on actions taken by the A. M. A. House of Delegates and on his own observations of the Chicago meeting. It was the consensus of the delegates reporting that the A. M. A. House of Delegates had taken considerable constructive action and that a more progressive and aggressive spirit was shown by the A. M. A. House of Delegates at the 1945 session than in previous years. Each delegate emphasized that throughout the entire session of the A. M. A. House of Delegates on many oc-

casions through actions and discussions, there was general agreement that state and local medical societies must become more vocal and aggressive and do more to improve and expand their activities, especially along the lines of public relations. The delegates stated that the programs and resolutions adopted by the American Medical Association must be activated by state and local societies and that state and local society organizations must be improved and expanded to meet these challenges. The delegates also stated that the Council on Medical Service and Public Relations of the A. M. A. received many favorable comments and that the American Medical Association took a definite stand on the matter of supporting and assisting prepaid medical service plans promoted by state and local medical societies, looking toward the possibility of a national organization to coordinate the activities of the state and local plans.

Following these reports The Council **adopted a motion** by Dr. McNamee and seconded by Dr. Dixon, expressing sincere appreciation to the Ohio delegates for the work which they did at the recent Chicago meeting and for attending this meeting of The Council.

MEDICAL CARE OF VETERANS

Dr. Schriver called attention to the address made by Major General Paul R. Hawley, head of the medical services of the Veterans Administration, at the November 11th conference of county society presidents and secretaries. He commended General Hawley's efforts to improve the medical program of that agency, especially through decentralization of the medical activities, the use of physicians in private practice for outpatient service, the use of private hospitals where feasible and the building of new veterans' hospitals in areas where the medical and hospital services can be coordinated with medical schools or with the services of specialists in medical centers. Action of the House of Delegates of the American Medical Association in endorsing General Hawley's program was referred to.

On motion by Dr. Brindley, seconded by Dr. McNamee, **and carried**, The Council unanimously voted its active and wholehearted support to General Hawley in his efforts to make the program, as outlined above, effective at the earliest possible date.

In order to provide a way through which the Ohio State Medical Association can materially assist General Hawley and cooperate with him and the Veterans Administration in working out a satisfactory program for the medical care of veterans within the State of Ohio, The Council **adopted a motion** by Dr. Dixon and seconded by Dr. Noble, abolishing the Committee on War Participation, which has served so efficiently and faithfully since before the outbreak of the war, and creating in lieu thereof a Committee on Medical Care of Veterans, the members of which are to be appointed by the President of the State Association.

In the same motion The Council instructed the Executive Secretary to officially request each county medical society to create a similar committee to work with the state committee and in consultation with the new state committee to devise a suitable program locally for handling the medical and health needs of veterans in cooperation with the Veterans Administration.

On motion by Dr. Sherburne, seconded by Dr. Messenger, **and carried**, the Executive Secretary was instructed to convey to the members of the Committee on War Participation the sincere appreciation of The Council for the work which that committee has done.

1946 ANNUAL MEETING

The Executive Secretary reported for the Committee on Scientific Work with respect to arrangements for the 1946 Annual Meeting, the Centennial Anniversary Meeting of the Ohio State Medical Association, to be held in Columbus on May 7, 8 and 9. It was reported that excellent guest speakers had been obtained for the meeting and that the committee would meet on January 6 to review the proposed section programs and to make final arrangements for the entire program. A special sub-committee consisting of Dr. Jonathan Forman, Columbus, Dr. David A. Tucker, Jr., Cincinnati, and Dr. Howard Dittrick, Cleveland, is at work on a number of historical features which will be a part of the Centennial Anniversary celebration, he reported.

OHIO MEDICAL INDEMNITY, INC.

A report was submitted to The Council from the Board of Directors of Ohio Medical Indemnity, Inc., which had met in regular session in Columbus on Saturday, December 15. It was pointed out that the company has obtained its authorization to transact business from the State Superintendent of Insurance and that agreements entered into with respect to administrative activities with the Hospital Care Corporation of Cincinnati also had been approved by the Superintendent of Insurance. It was stated that the agreement for the sharing of expenses for administrative activities and enumerating such activities will be signed by the proper officials of both organizations at an early date. It is expected that prior to the first of the year enrollment of subscribers will start in the 14-county area served by Hospital Care Corporation of Cincinnati. Negotiations will be carried on with the other Blue Cross Plans in Ohio, exclusive of the Cleveland area, on the matter of working out a mutually satisfactory agreement for the sharing of administrative responsibilities. Activi-

ties of the company will be expanded into other areas as soon as feasible.

SERVICES FOR RETURNING MEDICAL OFFICERS

The Executive Secretary reported on various services which are being rendered by the State Headquarters Office to returning medical officers, consisting of supplying information regarding openings for practice and data regarding refresher courses or residencies, prepared in booklet form under the direction of the Committee on Education. It was reported that the records of the State Association indicate that the policies of the Army and the Navy with respect to the release of medical officers has been modified considerably and that as a result a substantial number of Ohio physicians are now being released from the services, many of whom are resuming their practices and some of whom are entering refresher or postgraduate work.

COMMITTEE ON RURAL MEDICAL SERVICE

A communication from the American Medical Association, stating that a Committee on Rural Medical Service has been created by the A. M. A. and requesting all state societies to create a similar committee to work with farm groups on this question, was read. On **motion** by Dr. Sherburne, seconded by Dr. Dixon, and **carried**, the President was authorized to appoint a Committee on Rural Medical Service to hold conferences with farm groups in Ohio and cooperate with them on matters, looking toward the improvement of medical and health services for the rural districts in this state.

Reference was made also to a movement for the creation of an organization composed of representative business and professional groups in Ohio to carry on an active educational campaign for the improvement of economic and social conditions in the rural areas of Ohio. A communication from the Ohio Association of Trade Executives stated that that organization had approved this suggestion, believing that improvement in living standards in rural areas is not only of great importance to those residing in urban areas, but necessary to bring about general improvement in the economic and social standards of the state as a whole. One phase of the program would deal with the improvement of health services, including the production and consumption of proper nutritional and dietary values for all residing in rural communities.

Following a general discussion, The Council approved the general principles underlying the creation of such an organization and voted its cooperation with other groups and organizations, authorizing the Committee on Rural Medical Service, which will be appointed, to represent the State Association on this matter.

A communication from the Commission on Hospital Care of Ohio, recently appointed by Governor Lausche although a non-government and non-official committee, was read and discussed. The committee, working with the Commission on Hospital Care of the American Hospital Association, will make a survey of hospital services and facilities in Ohio and, in event the Hill-Burton bill is enacted by the Congress, will serve in an advisory capacity to the Ohio Department of Health on the matter of securing and allotting Federal funds for the building of additional hospital facilities in Ohio in areas where there is proven need for such facilities.

SURVEY OF HOSPITAL SERVICES AND FACILITIES

The communication requested the Ohio State Medical Association, which has representation on the Commission, to make a financial contribution to assist the Commission in carrying on its survey and activities. The letter pointed out that the Commission must raise funds from private sources for its work and that the Ohio Hospital Association already had appropriated $5,000.

On the recommendation of the Committee on Auditing and Appropriations and on **motion** by Dr. Brindley, seconded by Dr. Messenger, and **carried**, The Council authorized the appropriation of $5,000 to be contributed to the Commission on Hospital Care of Ohio, providing an additional $20,000 is pledged by other organizations and agencies, it being understood that a minimum of $25,000 would be required for the conduct of the survey.

JOINT COMMITTEE FOR THE CONTROL OF TUBERCULOSIS

A communicaton from Dr. J. B. Stocklen, President of the Ohio Public Health Association, outlining a plan to form a group known as the Joint Committee for the Control of Tuberculosis, was read. The letter requested the Ohio State Medical Association to name three representatives to serve on this committee, and that other organizations represented would be the Ohio Federation of Public Health Officials, the Ohio Hospital Association, the Ohio Public Health Association and the Ohio Conference of Tuberculosis Secretaries. It was stated that the work of the committee would be financed by the Ohio Public Health Association and that the purpose of the committee would be to assist the Ohio Department of Health in carrying out a tuberculosis program. It would endeavor to obtain funds from the Ohio General Assembly to erect the necessary state hospitals for the care of the tuberculous; a subsidy of $2.50 per patient per day to be paid by the state for the care of patients in local tuberculosis hospitals; and a regular appropriation of $50,000 per annum for

the operation of the Division of Tuberculosis of the Ohio Department of Health.

On **motion** by Dr. McNamee, seconded by Dr. Rutledge, and **carried,** The Council authorized President Schriver to name three persons to represent the Ohio State Medical Association on the joint committee.

REPORT OF COMMITTEE ON AUDITING AND APPROPRIATIONS

At this point The Council went into executive session to hear a report from Dr. Ralph Rutledge, chairman of the Committee on Auditing and Appropriations which had met on Saturday, December 15. The following recommendations of the committte on Auditing and Appropriations were submitted by Dr. Rutledge and acted upon by The Council:

The committee recommended that the President be authorized to appoint a special committee to study the matter of establishing a retirement plan for employes of the State Association and to report to The Council on this matter at some future meeting. On **motion** by Dr. McNamee, seconded by Dr. Harding, and **carried,** The Council **approved** this recommendation. (Under the authority granted him by The Council, President Schriver appointed as members of the committee to investigate this matter: Dr. Rutledge, chairman, Dr. Lincke and Dr. Harding, and Dr. McNamee, ex-officio.)

A communication from Mr. W. L. Stoneman, President of Stoneman Press, which Company has been printing *The Journal* of the Ohio State Medical Association for the past 41 years, was read. In his letter Mr. Stoneman pointed out that, because of increased labor costs and because of the increase in the costs of paper and other items, it would be necessary for Stoneman Press to increase the base cost of the printing of *The Ohio Medical Journal* during 1946 by 15 per cent. On **motion** by Dr. Sherburne, seconded by Dr. Lincke, and **carried,** a recommendation of the committee that the Business Manager of *The Journal* be authorized to enter into an agreement with the Stoneman Press for the printing of *The Ohio State Medical Journal* during 1946 at a base cost of 15 per cent higher than at present, was **approved.**

A recommendation of the committee that the Executive Secretary be authorized to renew the present fidelity bonds carried on employes of the State Association was **approved** on **motion** by Dr. Noble, seconded by Dr. Dixon, and **carried.**

The committee reported that in view of the actions taken by the American Medical Association, requesting the expansion and improvement of the programs and activities of the various state medical societies and in view of the vital questions which will confront the medical profession during the next several years, it was the recommendation of the committee that The Council provide additional personnel for the State Headquarters Office of the Association and that immediate steps be taken by The Council to provide additional funds for the Association in order that it can extend and expand its activities, especially in the field of public relations. Dr. Rutledge, reporting for the committee, presented the following specific recommendations for consideration of The Council:

1. That steps be taken immediately to reactivate and reorganize the Bureau of Public Education and that the name of the Bureau be changed to the Bureau of Public Relations.
2. That Mr. George H. Saville be appointed as Director of the Bureau of Public Relations, retaining at the same time the title of Assistant Executive Secretary.
3. That the Ohio State Medical Association employ immediately a competent man, preferably someone with newspaper training and training in organizational work, to serve as News Editor of *The Ohio State Medical Journal* and as assistant to Mr. Saville on matters of public relations.
4. That the Executive Secretary be authorized to immediately employ an additional stenographer so that suitable office help can be assigned to the Bureau of Public Relations and to the proposed News Editor of *The Journal.*

On **motion** by Dr. Sherburne, seconded by Dr. Noble, and **carried,** the foregoing recommendations of the committee were **approved, and** the President was authorized to appoint a committee to work with the Executive Secretary on the matter of securing the new employes authorized.

Dr. Rutledge reported that the committee had given very serious and lengthy consideration to the matter of providing proper funds for extension of the activities of the Association, especially in the field of public relations. He stated that the committee felt the public relations program of the Association must be expanded through the use of radio, literature to the lay public, newspaper publicity and advertising, if necessary, enlargement of a speakers' bureau and other activities. The committee stated that the Association would be unable to carry out a contemplated constructive program for improvement in the medical and health services and facilities in Ohio within its present budget and that it would be unable to take more vigorous action in combatting efforts being made to regiment and socialize the medical profession unless more funds are provided for necessary activities of this kind.

Therefore, Dr. Rutledge reported that the committee recommended to The Council that it in turn recommend to the House of Delegates, which will meet May 7, 8 and 9, 1946, that the House of Delegates authorize an increase in the annual dues of the Ohio State Medical Association to make the annual dues $15, effective January 1, 1947, and that the Committee on Public Relations and the Executive Secretary be instructed to prepare a digest of contemplated activities which would be carried on in event the income of the Association is increased in this manner. It was pointed out that, in event the House of Delegates adopts such a recommendation, certain reserve funds of the Association could be used immediately to initiate the new activities proposed and expand present activities not now feasible within current income.

On **motion** by Dr. Brindley, seconded by Dr. Noble, and **carried**, this recommendation of the committee **was approved.**

The committee then presented for consideration of The Council a proposed budget for the calendar year 1946, reading as follows, and which **was approved** on **motion** by Dr. Swartz, seconded by Dr. Sherburne, and **carried:**

BUDGET FOR 1946

The Ohio State Medical Journal	$10,000
Executive Secretary, Salary	8,200
Executive Secretary, Expense	1,000
Asst. Exec. Secretary, Salary	6,700
Asst. Exec. Secretary, Expense	800
Other Office Personnel	7,740
President, Expense	500
Council, Expense	900
Committee on Public Relations	6,000
Committee on Industrial Health	500
Committee on Medical Care of Veterans	500
Committee on Education	1,500
Committee on Medical Service Plans	200
Miscellaneous Committee Expense	200
Committee on Auditing and Appropriations	100
A. M. A. Delegates, Expense	1,600
Stationery and Supplies	1,200
Postage, Telephone, and Telegraph	2,300
Rent, Insurance, and Bonding	2,800
Annual Meeting	4,000
Total	$56,740

BETTER HOUSING PROGRAM

A communication from Mr. Bleecker Marquette, President of the Ohio Housing Council and Executive Secretary of the Better Housing League of Cincinnati and Hamilton County, was considered. The letter requested the Ohio State Medical Association to name someone to attend meetings of the Ohio Housing Council and act as liaison between that organization and the Ohio State Medical Association.

On motion by Dr. Rutledge, seconded by Dr. Dixon, **and carried,** The Council voted the cooperation of the Ohio State Medical Association on this matter and designated the Executive Secretary to represent the Association at meetings held by the Ohio Housing Council and to submit reports to The Council from time to time.

A letter from a representative of an insurance company, suggesting that the Ohio State Medical Association arrange for the establishment of a malpractice liability group insurance policy for the members of the Association, was read and discussed. It was the sense of The Council that the Ohio State Medical Association should not enter into any negotiations of this kind now, believing that this is a matter which should be left to local medical societies.

There being not further business, The Council adjourned to meet at the call of the President.

Attest: CHARLES S. NELSON,
Executive Secretary.

Course in Occupational Medicine Offered by Wayne University

Wayne University School of Occupational Health, Detroit, has announced a twelve-week orientation course in the field of Occupational Health and Medicine beginning January 7, 1946. This course is designed for physicians returning from the military service. It will be of especial value to physicians who were dislocated from industrial work in which they were engaged at the time they entered the service or physicians who may wish to enter the field of occupational medicine, as well as those physicians who may wish to include practice of occupational medicine in their future professional activities.

For further and more detailed information address: Doctor Raymond Hussey, Dean of the School of Occupational Health, Wayne University, 4072 Penobscot Building, Detroit 26, Michigan.

Prepaid Care Plans Booklet

The third edition of Memorandum No. 55, "Prepayment Medical Care Organizations", of the Bureau of Research and Statistics, Social Security Board, is now available through the U. S. Government Printing Office, at a cost of 25 cents. The revised edition contains data relative to a period early in 1945 and a description of 235 organizations in the United States and 16 in Canada.

Columbus—Dr. John R. Mitchell is the new president of the Metropolitan Health Council. He succeeds Dr. Russel G. Means.

Solicitation of Subscribers Is Started by Ohio Medical Indemnity, Inc., in 14-County Southwestern Ohio Area

SOLICITATION of subscribers has been started by Ohio Medical Indemnity, Inc., "the Doctors' Plan", inaugurated by the Ohio State Medical Association, in a Southwestern Ohio area comprising 14 counties.

This activity is being directed by Mr. Earl Kammer, who has been named general agent for Ohio Medical Indemnity, Inc., and has been so licensed by the Superintendent of Insurance. Mr. Kammer also is the Enrollment Director of Hospital Care Corporation of Cincinnati. The enrollment facilities of Hospital Care Corporation are being utilized under an agreement relating to administrative functions between Ohio Medical Indemnity, Inc., and Hospital Care Corporation of Cincinnati, the Blue Cross Hospitalization Plan serving Southwestern Ohio.

The following counties comprise the territory in which Ohio Medical Indemnity, Inc., has started its activities: Hamilton, Clermont, Brown, Adams, Highland, Clinton, Warren, Butler, Preble, Montgomery, Greene, Clark, Miami and Darke. For the time being, solicitation will be carried on only among the approximately 500,000 Blue Cross subscribers residing in these 14 counties.

PROSPECTS ARE GOOD

As the solicitation began, the prospects for early enrollment of a considerable number of substantial groups of employes were excellent. Meetings have been held with Blue Cross subscribers' committees of the area. These committees have expressed themselves as being enthusiastic regarding "the Doctors' Plan" and the indemnity contract which is being offered. (See December, 1945, issue of *The Journal* for complete analysis of the provisions of the indemnity contract.)

By authorization of the Board of Directors of Ohio Medical Indemnity, Inc., meeting in Columbus on December 15, conferences are being arranged between representatives of Ohio Medical Indemnity, Inc., and representatives of the Blue Cross Plans serving the Toledo, Lima, Portsmouth, Columbus, Canton, Akron and Youngstown areas to work out mutually satisfactory agreements on division of administrative functions, preliminary to inaugurating Ohio Medical Indemnity, Inc., activities in those communities.

WILL EXPAND TO OTHER AREAS

It is the objective of Ohio Medical Indemnity, Inc., to eventually offer its indemnity coverage for surgery and obstetrics to Blue Cross subscribers in all counties except those comprising the Cleveland area where subscribers are being given the opportunity to obtain similar coverage through Medical Mutual of Cleveland, an indemnity company organized through the initiative of the Cleveland Blue Cross Plan. There are more than 1,000,000 Blue Cross subscribers residing in the territory which will eventually be covered by Ohio Medical Indemnity, Inc., all of whom are potential subscribers to the medical indemnity coverage.

After Ohio Medical Indemnity, Inc., has gained experience and has acquired a substantial list of subscribers, the question of expanding the schedule of indemnities to include indemnities for additional procedures, including those which are non-surgical, will be considered by the Board of Directors.

SCHEDULE CAREFULLY DRAFTED

As stated clearly and definitely in the indemnity contract which is being offered to subscribers, the amounts of the indemnities in the schedule are not to be understood as fixing or attempting to fix the value of the services of the physician or surgeon. The indemnities will be paid in cash to the subscriber. The physician will bill the subscriber as in the past for services rendered.

In setting up the schedule of indemnities, officials of Ohio Medical Indemnity, Inc., have made an effort to establish indemnities which approximate the customary average fee now being charged persons of moderate means. It is believed that in most instances the indemnity paid will be adequate to cover the physician's fee. In exceptional cases, the subscriber will be obliged to pay to the physician the difference between the indemnity paid by the company and the fee bill submitted by the physician to the subscriber.

Dr. L. Howard Schriver, Cincinnati, President of the Ohio State Medical Association, participated in a radio discussion of the Wagner-Murray-Dingell bill and President Truman's national health program, over Station WJR, Detroit, Sunday, Nov. 25. Others on the program were: Congressman John Dingell, Detroit; Nelson Cruikshank, director of social security, A. F. of L, and Dr. G. L. McClellan, past-president of the Wayne County Medical Society of Detroit.

Dr. Dwight M. Palmer has been named chairman of a new department of neurology and psychiatry at Ohio State University College of Medicine.

Résumé of Important Actions Taken at Recent Chicago Meeting of House of Delegates of the A.M.A.

DELAYED for several months because of the ban on conventions, the House of Delegates of the American Medical Association met at the Palmer House in Chicago, December 3-5. Delegates from the Ohio State Medical Association were: Dr. Barney J. Hein, Toledo; Dr. Carl R. Steinke, Akron; Dr. C. C. Sherburne, Columbus; Dr. Wm. M. Skipp, Youngstown; Dr. Geo. A. Woodhouse, Pleasant Hill; Dr. Harry V. Paryzek, Cleveland; Dr. H. M. Platter, Columbus, and Dr. Parke G. Smith, Cincinnati.

Many resolutions were introduced pertaining to medico-economic, scientific and legislative questions, and after consideration by appropriate reference committees were acted upon by the delegates.

HIGH SPOTS OF BUSINESS TRANSACTED

Some of the most significant actions taken by the House follow:

1. Established a new Committee on Military Service to give careful consideration to all the communications which have been received by the A.M.A. from men in the service, so that difficulties that have prevailed during World War II may be overcome in any future emergency.

2. Requested the Board of Trustees to develop the Bureau of Information on a permanent basis; and to intensify its activities in furnishing returning veterans with information on suitable locations and postgraduate opportunities.

3. Directed the Board of Trustees to expand and amplify the public relations activities of the Association, and requested state and local societies also to increase their activity in that field.

4. Established a Section on General Practice as a permanent scientific section.

5. Directed the Council on Medical Service and Public Relations and Board of Trustees to co-ordinate the prepaid medical care plans being sponsored by state medical societies and to promote a national medical care plan to provide coverage in those areas in which local plans are not in operation.

6. Expressed opposition to the compulsory sickness insurance features of President Truman's program and the current Wagner-Murray-Dingell Bills; and the Pepper Bill which would make maternity and infant care available at government expense to anyone, regardless of need.

7. Clarified the responsibilities and duties of the various councils, bureaus and officers in the headquarters office.

8. Recommended a new by-law which will provide for two meetings of the House of Delegates each year.

9. Approved a resolution instructing the the Council on Medical Service and Public Relations to take steps toward organizing a National Health Congress composed of representatives of the medical, dental, nursing, pharmacy professions, and other allied groups, including hospitals, for the purpose of bringing about coordinated thinking and action on health matters.

10. Endorsed an educational campaign to inform the people regarding the benefits of animal experimentation to offset attempts which are being made to interfere with this method of scientific research.

11. Declined to take action on a resolution calling for the licensing of honorably discharged medical officers without examination, holding that this is a question to be decided by the individual states.

12. Approved a resolution calling for modification of the Selective Service regulations so as to permit deferment of young men for premedical education.

13. Voted to request greater recognition of the Medical Department of the Army, recommending that the Surgeon General be made directly responsible to the chief of staff of the Army.

14. Endorsed legislation proposing transfer of the U. S. Children's Bureau from the Labor Department to the Federal Security Agency.

15. Requested Council on Medical Education and Hospitals to take steps to provide more prompt recognition of hospitals for residencies and, if feasible, give temporary approval to residencies until formal inspection can be made.

16. Strongly urged early release of medical officers from the armed forces.

17. Voted cooperation with nursing organizations on matters involving nursing problems and nurse education.

HAWLEY ASKED FOR SUPPORT

One of the highspots of the meeting was an address by Maj. Gen. Paul R. Hawley, acting surgeon general of the Veterans Administration, in which he asked for the support of the profession in his plans to furnish the best of

medical care to veterans, with a minimum of governmental red tape and the utilization of all competent physicians in private practice. Referring to plans for the socialization of medical practice, Gen. Hawley said:

"Although I've been in government service for 30 years, I don't want to see government-controlled medicine. . . . Free and uncontrolled medicine can solve its own problems and doesn't need the government to tell it how."

The House of Delegates officially endorsed his program and offered the support of organized medicine.

DR. SHOULDERS NEW PRESIDENT-ELECT

Dr. Harrison H. Shoulders, Nashville, Tenn., for many years Speaker of the House of Delegates, was elected President-Elect, in a three-cornered race. The other candidates were Dr. Edward J. McCormick, Toledo, chairman of the Council on Medical Service and Public Relations, and Capt. Alphonse McMahon, M.C., U.S.N.R., St. Louis, Mo.

From 1927-1945 secretary-editor of the Tennessee State Medical Association, Dr. Shoulders represented that association in the A.M.A. House of Delegates from 1930 to 1938, when he became Speaker of the House. Dr. Shoulders graduated at the University of Nashville Medical Department in 1909. He is a member of the Founders Group of the American Board of Surgery; Fellow of the American College of Surgeons; assistant professor of clinical surgery at Vanderbilt University Medical School. Dr. Shoulders was an organizer and first president of the Nashville Surgical Society.

Dr. R. W. Fouts, Omaha, was elected speaker, succeeding Dr. Shoulders, and Dr. F. F. Borzell, Philadelphia, was elected vice speaker, succeeding Dr. Fouts.

OTHER OFFICERS NAMED

Other officers elected were: Vice-President, Dr. William R. Molony, Los Angeles; three new members of the Board of Trustees, Dr. John R. Fitzgibbon, Portland, Ore.; Dr. James R. Miller Hartford, Conn., and Dr. Dwight H. Murray, Napa, Calif.; Secretary, Dr. Olin West, Chicago; Treasurer, Dr. Josiah J. Moore, Chicago. Dr. Herman G. Weiskotten, Syracuse, N.Y., was re-elected to the Council on Medical Education and Hospitals; Dr. Henry R. Viets, Boston, to the Council on Scientific Assembly and Dr. Louie A. Buie, Rochester, Minn., to the Judicial Council. Those elected to the Council on Medical Service and Public Relations were: Dr. Alfred W. Adson, Rochester, Minn., Dr. Walter B. Martin, Norfolk, Va., and Dr. Raymond L. Zech, Seattle.

The Distinguished Service Award of the American Medical Association was presented by action of the House of Delegates to Dr. George R. Minot, Boston.

The next annual session of the Association will be held in San Francisco, July 1-5, 1946. Plans are under way for the centennial meeting in Atlantic City in 1947.

The Ohio delegates were active during the various sessions at Chicago. The following had important reference committee appointments: Dr. Steinke, chairman, Amendments to the Constitution and By-Laws; Dr. Paryzek, Postwar Planning; Dr. Smith, Medical Care of Veterans; Dr. Hein, Industrial Health.

CONFERENCE ON PREPAID PLANS

A conference on prepaid medical plans sponsored by the Council on Medical Service and Public Relations, Nov. 30-Dec. 1, was attended by Dr. L. Howard Schriver, Cincinnati, President of the Ohio State Medical Association, and by Charles S. Nelson, executive secretary, and George H. Saville, assistant executive secretary. They participated also in a conference of presidents and secretaries of state medical societies held on Dec. 2. Dr. Schriver was chairman of the reference committee on resolutions of the presidents' conference, where many of the more important resolutions subsequently considered by the House of Delegates of the American Medical Association had their origin. Mr. Nelson and Mr. Saville also took part in meetings at which activities of the Cooperative Advertising Bureau were discussed. These meetings were held Nov. 30 and Dec. 1.

The detailed minutes of the House of Delegates session appeared in the Dec. 15 and 22 issues of *The Journal of the American Medical Association.*

Time, Inc., publisher of *Time, Life, Fortune,* and the *Architectural Forum,* and producer of *The March of Time,* New York City, is the first organization to enroll its employees in a new all-coverage medical plan, which provides for prepayment of medical care in the home, the doctor's office as well as in the hospital. The premiums—$1.60 for a single subscriber and $4 for a family—are being met by Time, Inc. The concern's employees have been enrolled in Blue Cross for several years.

Dr. Claude S. Perry, Columbus, has been named acting chairman of the Department of Ophthalmology, Ohio State University College of Medicine. Advanced to the rank of associate professor, Dr. Perry succeeds the late Dr. Albert D. Frost.

There are 86 Blue Cross hospitalization plans operating in the United States. Only five states are not served by such plans. They are: Arkansas, Mississippi, South Carolina, Idaho and Wyoming, comprising about five per cent of the total population of the United States.

VETERANS' INQUIRY DEPARTMENT

Ohio Openings and Locations Sought by Returning Medical Officers; Opportunities Available Listed

A SUFFICIENT amount of interest has been shown in this feature—the Veterans' Inquiry Department—to warrant its continuation. Some new information will be found in this—the second installment—which will be of interest to veterans as well as those seeking the services of physicians.

The purpose of the new department is to provide space without cost to Ohio veteran physicians for the publication of inquiries they may wish to make concerning an assistantship or residency, a partnership or space in an office, locations and purchase of a practice, purchase of equipment, etc.

This new feature also offers an opportunity for physicians who desire to dispose of their practice or institutions and agencies needing staff physicians to publicize this information for the benefit of service men.

The feature will appear monthly as long as there seems to be a need for it. The regulations governing it are: (1) The veteran submitting the inquiry must be an Ohio physician, i.e., one who was in practice in Ohio when he entered the service or was a native of Ohio but still in training when he entered in the service. (2) Inquiries should not exceed 35 words. (3) Copy must be submitted by the 20th day of the month preceding date of publication. (4) Unless otherwise specified, each inquiry will be carried in two consecutive issues of *The Journal* but no oftener. (5) *The Journal* reserves the right to reject or edit copy submitted; also, to eliminate the new department when and if conditions warrant. (6) Inquiries should be accompanied by full name, forwarding address and identifying data.

OPPORTUNITIES SOUGHT

PEDIATRICIAN: Navy medical officer, aged 33, graduate of Ohio State University College of Medicine, trained in pediatrics, interested in pediatrics practice—preferably with group clinic. V.I.D. No. 1, care of Ohio State Medical Journal.

GENERAL SURGERY: Discharged Army medical officer, age 35, graduate of Northwestern University Medical School, surgical residency in approved Ohio hospital, seeking general surgical practice in Ohio or associateship or assistantship with man in practice. V.I.D. No. 2, care of Ohio State Medical Journal.

OTOLARYNGOLOGY TRAINING: Training in Otolaryngology through residency or assistantship sought by Army medical officer to be separated from service soon; age 32; graduate of Ohio State University College of Medicine. V.I.D. No. 3, care of Ohio State Medical Journal.

OBSTETRICAL TRAINING: Discharged medical officer desires assistantship or short residency in obstetrics and gynecological surgery or general surgery for period of month, six weeks or two months; age 48; graduate of St. Louis University School of Medicine. V.I.D. No. 4, care of Ohio State Medical Journal.

SURGICAL ASSISTANTSHIP: Wanted by veteran, age 33; six years surgical training including year of thoracic surgery; four years of Army surgery in states and overseas. Available after January 2. Ohio license. V.I.D. No. 5, care of Ohio State Medical Journal.

SURGICAL PRACTICE: Discharged medical officer, age 32, graduate of Ohio State University College of Medicine and residency in surgery, University Hospitals, Minneapolis, desires surgical practice. V.I.D., No. 6, care of Ohio State Medical Journal.

EQUIPMENT NEEDED: Returning medical officer desires to purchase an Ear, Nose and Throat Unit, new, or second hand if in good condition. V.I.D., No. 7, care of Ohio State Medical Journal.

PEDIATRICS OR GENERAL PRACTICE: Practice in pediatrics or general practice sought by discharged Army medical officer, 45 years of age, diplomate of American Board of Pediatrics. Willing to invest. Available immediately. V. I. D. No. 8, care of Ohio State Medical Journal.

LOCUM TENENS OR ASSISTANTSHIP: Wanted for eight months by discharged flight surgeon who will begin ENT postgraduate course Sept. 1; O.S.U. '37; aged 32; experienced in industrial surgical practice. V.I.D. No. 9, care of Ohio State Medical Journal.

SURGICAL RESIDENCY WANTED: By returning medical officer, age 46, with 15 years general practice and surgery; three years assistanceship to general surgeon; 20 months in general surgery in Army overseas. Available after January 1. V.I.D. No. 10, care of Ohio State Medical Journal.

OPPORTUNITIES OFFERED

FOR SALE: Complete office equipment of Dr. J. T. McVey, deceased. Call or write Mrs. J. T. McVey, Bremen, Ohio; telephone 205.

PRACTICE FOR SALE: Physician desiring to retire wishes to dispose of practice in Byesville, Guernsey County. Town of about 3,000. No competition. New factory to locate in town, employing 900 to 1,200 persons. Modern advantages. Property, suitable for 10-bed clinic, available for rent. J. E. Patton, M. D., Byesville.

GENERAL PRACTICE: Opportunity for general practice in town of 1,000 in Northwestern Ohio. Only one other physician. Home and office space available. One of Ohio's best agricultural areas and good marketing section. Write W. L. G., care of Ohio State Medical Journal.

STUDENT HEALTH SERVICE: Opening at Ohio University, Athens, in Student Health Service on trial basis, if desirable, with view to permanent arrangement later. Student enrollment about 2,000. Well-organized service, with small hospital and X-ray equipment. Young medical graduate preferred, but will consider others. Write or see Dr. E. H. Hudson, director, Student Health Service, Ohio University, Athens; telephone 24532.

GENERAL PRACTICE AVAILABLE: Physician wishing to retire wants to dispose of practice to returning veteran. Located in Wilmington, Clinton County, excellent farming community; good roads. Equipment includes modern furniture, large supply of drugs, supplies and instruments and library. Office rent reasonable and equipment and practice priced to sell immediately. R. H. Vance, M.D., 114 East Locust Street, Wilmington.

PLACE FOR GENERAL PRACTITIONER: Civic Association of Alger, Hardin County, population of 857, sponsoring project to secure physician for area. Good farming district and modern improvements. Good opportunity for

energetic doctor. Communicate with Mr. Glenn Hanson, president, Alger Civic Association.

WANTED: Physician, for $25,000 practice in town of 3,000 with drawing population of 30,000 in Northeastern Ohio. Practice combined surgery and internal medicine. Modern 15-room clinic building, including 6-bed ward, of deceased physician, with $15,000 worth of equipment, X-ray, laboratory facilities, instruments, supplies, library and records available at reasonable terms. G.A.T., in care of Ohio State Medical Journal.

INDUSTRIAL POSITION: Desirable position on medical staff of large rubber company; good salary. F.T.R., care of Ohio State Medical Journal.

EQUIPMENT AVAILABLE: Physician desiring to retire from large general practice will dispose of equipment, complete except an E.C.G. but including X-ray 100 milli., colorimeter, electric centrifuge, short wave, etc., to returning veteran. W.S., care of Ohio State Medical Journal.

INDUSTRIAL COMMISSION: Openings available in Medical Section, Ohio Industrial Commission. Consult Dr. Robert André, chief supervisor, Medical Section, State Office Bldg., Columbus.

PRACTICE AND OFFICE FOR SALE: Practice in community of 2,000, unopposed; modern six-room recently constructed brick office building for sale or rent. Combined industrial and rural practice. H.B.K., care of Ohio State Medical Journal.

OFFICE SPACE TO SHARE: Space available in large city. Within year plan to move to an office in home. Will sublet smaller office rooms; common waiting room and use of space in larger office room except during my office hours. Prefer man in general practice, internist or pediatrician. B.G.S., care of Ohio State Medical Journal.

PARTNERSHIP: Good location for young M.D. Will consider partnership, nothing to sell. Five-room apartment above office available for living quarters. Contact Dr. A. B. Martin, Blanchester, Ohio.

E.N.T. PRACTICE AVAILABLE: Due to sudden death of Dr. Horace F. Tangeman, Cincinnati otolaryngologist, there is available for purchase his practice and equipment which is extensive and complete. Equipment includes several sets of treatment and surgical instruments of highest quality. Office on Sixth Floor, Union Central Bldg., Cincinnati, ready for immediate occupancy. Communicate with John N. Gatch, attorney for executrix, 1421 Union Central Bldg., Cincinnati.

EMPLOYMENT OPPORTUNITIES: For physicians, good salary, institution for mentally deficient. Indiana license necessary. Write or wire Fort Wayne School, Fort Wayne 1, Indiana.

ASSISTANT DIVISION CHIEF: Position for physician as Assistant Chief, Division of Child Hygiene, Ohio Department of Health, available. Salary $4,400 to $4,800. Must be graduate of approved medical school, one year's internship and at least one year's graduate training, plus one year of training or experience in clinical pediatrics. Experience in maternal and child health desirable. Must be licensed in Ohio or eligible for licensure. Apply, Chief of Division of Child Hygiene, Ohio Department of Health, State Departments Building, Columbus 15.

STATE HOSPITAL STAFF OPENINGS: Staff physicians for various institutions serving the mentally ill, mentally defective and epileptic needed. Physicians who have had some psychiatric training or experience preferred but can offer positions to doctors who may be interested in becoming acquainted with the specialty. Two positions of special importance now open are: Superintendency, Youngstown Receiving Hospital (especially attractive for young physician with residency in psychiatry) and Clinical Directorship, Gallipolis State Institute (fine opportunity for man who has had neuropsychiatric training to become acquainted with those neurological conditions that cause epilepsy in addition to a chance to be a specialist in the field of true epilepsy). Consult Dr. Frank F. Tallman, Ohio Commissioner of Mental Hygiene, State Departments Building, Columbus 15.

PUBLIC HEALTH OFFICERS NEEDED: Several counties in Ohio in need of full-time health commissioners. Those with training and experience, or interested in public health work, may obtain complete details from Dr. Roger Heering, Ohio Director of Health, State Departments Building, Columbus 15.

AREAS NEEDING PHYSICIANS: A list of Ohio areas badly in need of physicians, primarily for general practice—communities which were not the residence of any medical officer prior to the war—will be furnished on inquiry by the Headquarters Office, Ohio State Medical Association, Columbus.

PRACTICE FOR SALE: Active practice in county seat, Northwestern Ohio, for sale. Average of 100 obstetrical cases a year. Most physicians in upper age group. Railroad and insurance appointments available. Introduction and help for limited time offered. Equipment includes X-ray, diathermy, modern furniture, complete tonsillectomy instruments, large supply of drugs and supplies. Complete records of patients on file. No real estate for sale. Nominal rent. Hospitals nearby. Thriving industries and fine agriculture community, with paved roads. Estimated price, without complete inventory, $4,000 to $5,000. Box X, Ohio State Medical Journal.

PRACTICE FOR SALE: Active practice in a community of 3,000, North Central Ohio. Large amount of industrial work in addition to regular practice. Equipment includes new X-ray, diathermy, modern furniture, drugs and supplies. No real estate for sale. Moderate rent. Estimated price $7,500, cash or terms. Will introduce for a short time. Write R.J.S., care of Ohio State Medical Journal.

New Mental Receiving Hospital To Be Part of O.S.U. Medical Center

A new receiving hospital for the mentally ill is to be constructed on the campus of the Ohio State University, and operated in conjunction with the $5,000,000 University Medical Center for which funds were appropriated at last year's session of the Legislature.

Under an agreement between the University and the Ohio Welfare Department, the State Division of Mental Hygiene will have supervision over the receiving hospital. Patients there will be available to the medical center for clinical and teaching purposes. The medical center in turn will make all its facilities available to the receiving hospital. It is anticipated that physicians on the staffs of the state mental hospitals will come to the center and the receiving hospital periodically for study and training in new methods of treatment.

Plans for the receiving hospital will be drawn by the same architect who is designing the medical center. The two institutions are to be erected near the present University Hospital.

New Names Given Ohio Offices of Veterans Administration

The use of the term "Facility" is no longer used as designating Veterans Administration activities, according to instructions from General Omar Bradley, administrator. Where straight hospital activities are furnished the station will be known as "Veterans Administration Hospital".

Where straight regional activities are carried on the station will be known as "Veterans Administration Regional Office". Stations primarily domiciliary will be termed "Veterans Administration Homes". Stations that combine regional activities and hospital or domiciliary services will be termed "Veterans Administration Centers".

In Ohio, therefore, are now located: Cleveland Veterans Administration Regional Office, Brecksville Veterans Administration Hospital, Dayton Veterans Administration Center, and Chillicothe Veterans Administration Hospital.

"Smoothage" IN THE CONSTIPATION OF PREGNANCY



The constipation frequently encountered during pregnancy, due to pressure of the fetus on the pelvic bowel, lack of exercise, and restricted diet, is alleviated by Metamucil.

The Smoothage of Metamucil encourages easy, gentle evacuation. It does not interfere with the absorption of vitamins or other food factors:

"Smoothage" describes the gentle, nonirritating action of Metamucil—the highly refined mucilloid of a seed of the psyllium group, Plantago ovata (50%), combined with dextrose (50%).

METAMUCIL *is the registered trademark of G. D. Searle & Co., Chicago 80, Illinois*

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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

Committee on Medical Care of Veterans Named To Work With Veterans Administration, Draft Program for Ohio, Assist in Establishing Local Plans

PROBABLY one of the most important questions which will confront the medical profession during the next several years will be that involving the establishment and operation of suitable programs to provide medical and health services for veterans of World War II.

Under legislation which has been passed by the Congress, or will be enacted, large numbers of World War II veterans will be eligible for medical and health services at government expense. On the medical profession rests the responsibility, in cooperation with the Veterans Administration, of setting up proper and adequate programs to provide these services.

Those who attended the Conference of County Society Presidents and Secretaries, sponsored by the Ohio State Medical Association in Columbus last November 11, or those who read the report of that conference, published in the December issue of *The Journal*, are familiar with the policies and views of Maj. Gen. Paul R. Hawley, medical director, Veterans Administration, on this matter.

GENERAL HAWLEY'S POLICIES

In brief, General Hawley wants "every physician in each community designated as a veterans' physician and insofar as possible for the veteran to choose his own physician in his own community like any other person in the community does".

In other words, General Hawley believes the great part of the job of providing veterans with medical and health services should, and must, be done by physicians in private practice rather than through a gigantic institutionalized, bureaucratic system.

He has solicited the help and counsel of the medical profession. He wants the profession through its national, state and local medical societies to work out and place in operation plans and programs which are feasible for a variety of local situations but which in the final analysis will make it possible for the veteran to select his own physician from among the private practitioners of his home community, thus maintaining for veterans and physicians the patient-physician relationship.

WANTS HELP OF PROFESSION

Moreover, General Hawley has sought the advice of the medical profession on ways to improve the quality of medical services in veterans' hospitals. He desires to make these institutions eligible for approval for the training of interns and residents. Also, he is insisting that new hospitals when needed be built in areas where they can be coordinated with medical schools or with the work of large medical centers, amply supplied with specialists and well-qualified medical personnel.

These are the responsibilities which confront the medical profession on January 1, 1946. It can just about write its own ticket under General Hawley's broad and liberal policies. Its ideas for suitable local programs will be given prompt and sincere consideration by the Veterans Administration. These will receive the blessing and support of General Hawley and his staff if practical and if there is reasonable assurance that the proposal, or proposals, will provide veterans with good medical and health services.

To provide an agency which can represent the medical profession of Ohio on these important matters, work with General Hawley and devise means of setting up sound veterans' medical care programs throughout Ohio, The Council of the Ohio State Medical Association on December 16 authorized the creation of a Committee on Medical Care of Veterans. (See Proceedings of The Council elsewhere in this issue.)

PERSONNEL OF NEW COMMITTEE

By authorization of The Council, President Schriver has appointed the following as members of the new committee:

Dr. Harry V. Paryzek, Cleveland, former president of the Ohio State Medical Association, chairman,
Dr. Robert Conard, Wilmington,
Dr. D. W. Heusinkveld, Cincinnati,
Dr. Paul I. Hoxworth, Cincinnati,
Dr. Harry R. Huston, Dayton,
Dr. W. W. Trostel, Piqua,
Dr. W. W. Green, Toledo,
Dr. Herbert W. Wright, Cleveland,
Dr. E. C. Northrup, Jr., Marietta,
Dr. Drew L. Davies, Columbus,
Dr. Robert L. Eastman, Mt. Vernon,
Dr. Frank F. Tallman, Columbus, State Commissioner of Mental Diseases,
Dr. John H. Marshall, Findlay,
Dr. Gordon G. Nelson, Youngstown,
Dr. Lewis W. Cellio, Carrollton,
Dr. Charles L. Shafer, Mansfield,
Dr. L. Dow Allard, Portsmouth.

Among the committee personnel, Drs. Huston, Trostel, Green, Wright, Northrup, Davies, East-

HAVE YOU PAID YOUR 1946 DUES?

HAVE you kept your annual date with the Secretary-Treasurer of your County Medical Society?

In other words, have you paid your 1946 State Association and County Society dues?

Dues are due and payable on or before January 1 annually. To retain your name on the membership roster of the State Association, annual dues must be paid to your local Secretary-Treasurer for him to transmit to the Columbus office.

After March 1, *The Ohio State Medical Journal* can not be sent to unpaid members.

Therefore, it is important for all to pay their dues immediately. See your local Secretary-Treasurer about this today.

man, Marshall, Nelson, Cellio, Shafer and Allard served with the medical corps of either the Army or Navy during World War II.

PROPOSED ACTIVITIES ENUMERATED

In general, the duties and responsibilities of the Committee on Medical Care of Veterans will be (1) to serve as a liaison between the medical profession of Ohio and the Veterans Administration; (2) to serve as a liaison between the State Association and its component county medical societies on medical and health matters dealing with veterans; (3) to cooperate with other organizations and to represent the State Association in state-wide activities dealing with veterans' medical and health questions; (4) to serve in an advisory capacity to General Hawley on medical and health questions concerning Ohio veterans; (5) to cooperate with and assist the Veterans Administration whenever and wherever possible; (6) to draft general policies and procedures for the guidance of county medical societies; (7) to assist county medical societies in setting up suitable local medical and health programs for veterans.

In taking this action The Council also decided to officially request each county medical society in Ohio to establish a similar local committee to work with the state committee and to take the leadership in establishing a veterans' program locally under the general guidance and with the assistance of the state committee.

Dr. Paryzek, chairman of the new state committtee, is planning to confer with General Hawley in the near future on matters of general policy. Shortly thereafter he will call a meeting of the committee for the purpose of starting work on this important activity.

Ohio's Silicosis Record

Statistics compiled by Safety Advisor Don Hanna, specializing in dust control in Ohio industries, show that since silicosis was made a compensable occupational disease on July 31, 1937, there have been 2,046 silicosis claims filed with the Industrial Commission.

While 877 of these claims have been allowed, 928 were disallowed and 241 are still pending.

Considering approved claims only, 504, or 57.4 per cent, originated in foundries, 276 in iron foundries, 130 in steel foundries and 98 in nonferrous foundries.

The ceramic industry is charged with 269, or 30.1 per cent of the allowed claims, distributed as follows: Building brick and tile 2, enamels 5, fire-brick 8, floor and wall tile 60, glass house refractories 18, insulating brick 9, electric insulators 19, silica brick 11, silica sand and diatomaceous earth 11, stoneware 13, tableware 96, sanitary ware 11 and glass 6.

The handling and working of cut stone gave rise to 43 cases, divided as follows: Monument work 31, quarries 4 and building stone 8.

Polishing, buffing and grinding are credited with 14 claims, all in iron and steel work.

Bricklayers were compensated in 18 claims, 16 from work in steel mills and 2 in glass plants.

Coal miners were given awards in 5 cases and 23 were from miscellaneous industries.

The figures given constitute the silicosis record up to August 31, 1945.—*O. I. C. Monitor*, Dec., 1945.

Delaware—Dr. George T. Blydenburgh, director of the Student Health Service, Ohio Wesleyan University, spoke on "Community Health" at a recent meeting of the P.T.A.

Army and Navy Discharge Standards Cut, Effective Jan. 1, Making Many More Doctors Eligible for Early Release

THOUSANDS of additional physicians should be released from military service promptly under revised discharge point systems announced by the Navy and Army, effective January 1, 1946.

Under the revised Navy release program, medical officers with 51 points, instead of 53 points will be eligible for release. After February 1, those with 50 points will become eligible for discharge.

According to War Department officials, well over two-thirds of the Army medical officers who were on duty as of V-E Day have been made eligible for release under former discharge plans or under the one which became effective January 1. It was announced that 15,000 had been released up to December 15.

Under the newly-announced Army point system, a medical officer, listed in a non-essential category, with 65, instead of 70 points, will become eligible for release.

HIGHER POINTS FOR SPECIALISTS

The time factor for non-essential Army medical officers has been cut. Instead of service prior to Pearl Harbor, medical personnel in that classification will now be eligible for release if they have had 42 months of honorable service. In addition, any physician in the same category who is 45 years of age to his nearest birthday, instead of 48 years of age, becomes eligible to return to civilian life.

The new standards will not apply to Army medical officers in certain scarce categories. The requirements for the scarce specialists vary from 70 points or 45 months of service or 45 years of age, to 80 points or service prior to Pearl Harbor or age 48, depending on the specialty.

The number of doctors in these categories is relatively small it was stated, but they are essential to the effective care of the 115,000 sick and wounded patients returned from overseas who are now in Army General Hospitals in this country. In the case of all Medical Department officers, provision is made for their retention on duty for a period of not more than 90 days if their services are essential and no replacement is available.

TRANSPORTATION PRIORITY GIVEN

Secretary of War Patterson has directed that transportation priority be given to medical personnel eligible for return from Europe and the Pacific. He has also designated two officers to go to Europe as his personal representatives to make an investigation of the release of medical officers there. A similar investigation was recently completed in the Pacific area.

Liberalized discharge standards also have been established for nurses and other Medical Department personnel. The point score for nurses has been cut from 35 to 25 and the Medical Department personnel. The point score for nurses has been cut from 35 to 25 and the discharge age from 35 to 30. Nurses will also be eligible for discharge after two years of service. Those on duty in the United States who are classed as limited service have been added to the list of those qualified for discharge. It is estimated that this will make 12,500 nurses eligible for release, in addition to the 27,000 who have already been qualified to return to civilian life. Twenty-two thousand nurses have been discharged to date. The peak strength of the Army Nurse Corps was 57,000.

For officers of the Medical Administrative Corps the score has been dropped from 70 to 60, and the pre-Pearl Harbor service requirement has been eliminated and the time of service required for discharge cut to 42 months. The age requirement stays at 42 for MAC officers. Four thousand officers are made eligible for discharge under the new standards.

The score for physical therapists has been reduced from 40 to 25 and the age requirement from 40 to 30. Two years of service will also qualify a physical therapist for discharge. Five hundred women officers are affected.

Three hundred additional dietitians have been made eligible to leave the Army by a cut in their score from 40 points to 30 and in their age requirement from 40 to 35.

Officers of the Sanitary Corps will need 60 points for discharge, instead of 70. They will also qualify for release if they have had 42 months of service or are 42 years old. For officers of the Veterinary Corps the score has been cut from 80 to 70. It is estimated that 350 Sanitary Corps officers and 400 Veterinary Corps officers will leave the service as a result of the liberalized rules.

EUROPE BOTTLENECK PROBED

Representatives of the Secretary of War who have departed for Europe to study the release of Army doctors and dentists are Colonel Polling R. Powell, Jr., of the Legislative and Liaison Division, of the War Department General Staff, and Colonel Durward G. Hall, Chief of Personnel Service of The Surgeon General's Office.

Colonel Powell and Colonel Hall have been given full power by the Secretary of War to

Not for just a year

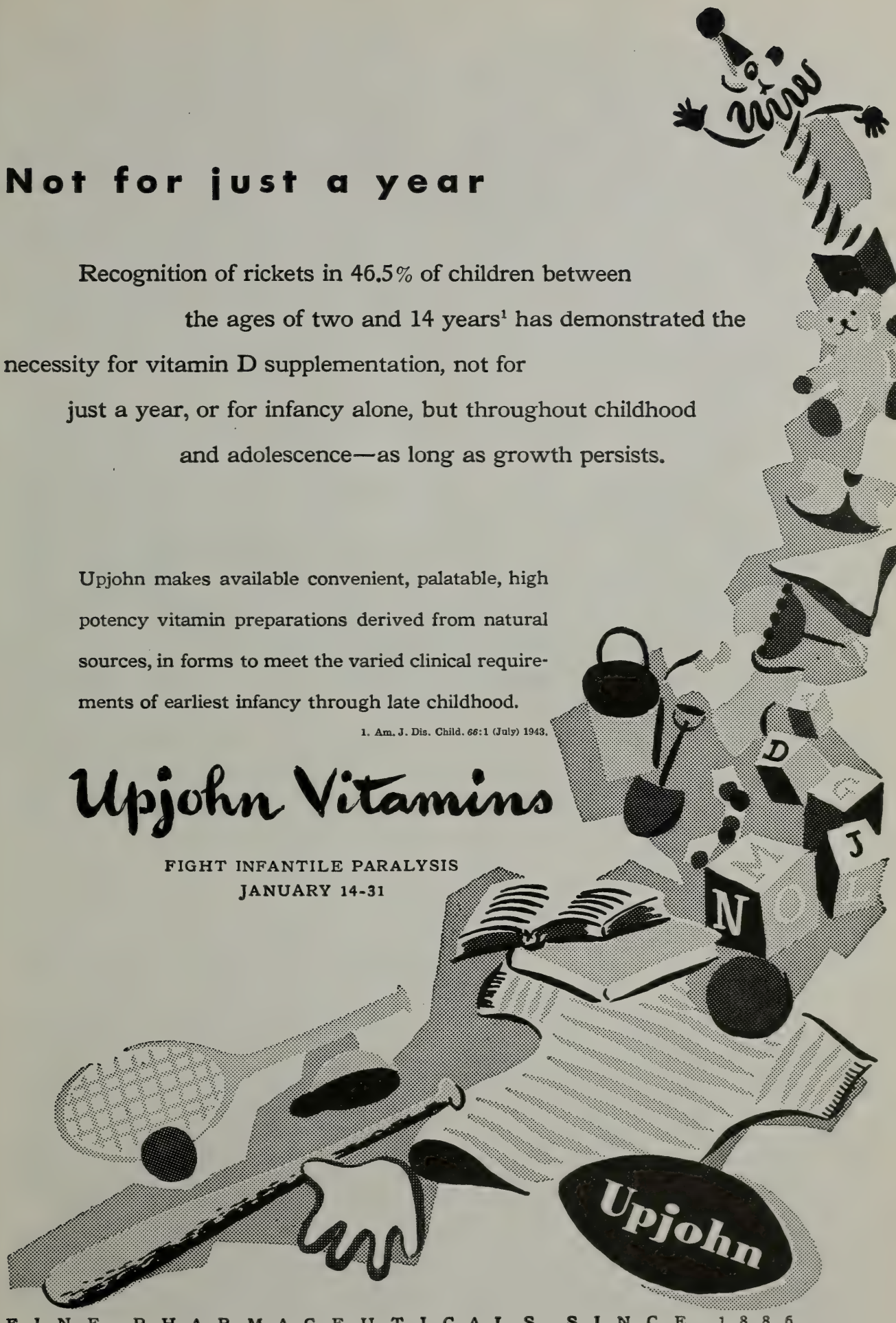
Recognition of rickets in 46.5% of children between the ages of two and 14 years[1] has demonstrated the necessity for vitamin D supplementation, not for just a year, or for infancy alone, but throughout childhood and adolescence—as long as growth persists.

Upjohn makes available convenient, palatable, high potency vitamin preparations derived from natural sources, in forms to meet the varied clinical requirements of earliest infancy through late childhood.

1. Am. J. Dis. Child. *66*:1 (July) 1943.

Upjohn Vitamins

FIGHT INFANTILE PARALYSIS
JANUARY 14-31



FINE PHARMACEUTICALS SINCE 1886

Kalamazoo 99, Michigan

make a complete investigation of all pertinent facts relating to Army doctors and dentists so that all necessary steps can be taken to expedite the return of all doctors who can be spared.

They will determine the medical and dental strength now necessary for each overseas theater so that all surplus professional officers can be immediately shipped out and either be released or assigned to replace doctors who are eligible for release.

In addition to studying the needed strength of doctors in each area, the Secretary of War's representatives will also investigate if there has been any undue delay in returning doctors who have been declared surplus and if so, make recommendations for the immediate correction of such situations.

Another phase of the study will be the determination of the number of hospital beds needed to meet present conditions in the European theaters with the idea of releasing unnecessary beds.

An investigation is also planned in this country of Service Forces, Ground Forces and Air Forces installations to make sure that medical and dental staffs are cut as rapidly as their work loads permit, and the discharge criteria are kept adjusted so that those doctors who are actually surplus will be released at once.

Ohioans Named to Red Cross Health Services Advisory Board

Basil O'Connor, National Red Cross chairman, has announced appointment of an Advisory Board on Health Services to coordinate activities of the American Red Cross in the health field. Named as board chairman was Lewis H. Weed, M.D., Baltimore. Dr. Weed also is chairman of the medical sciences division of the National Research Council; and director, School of Medicine, Johns Hopkins University. The committee consists of 109 men and women from 25 states and the District of Columbia, representing every specialty in the field of health.

Three members of the advisory board will serve as general vice-chairman. They are: Roger I. Lee, M.D., Boston, Mass., president of the American Medical Association; John D. Lyttle, M.D., Los Angeles, Calif., and John Romano, M.D., Cincinnati, Ohio, head of the Department of Psychiatry, University of Cincinnati.

Among members of the board are Charles A. Doan, M.D., Columbus, dean, College of Medicine, Ohio State University, and A. A. Weech, M.D., head of the Department of Pediatrics, University of Cincinnati.

Findlay—Dr. L. C. Goodman, recently returned from military service, was guest speaker at a meeting of the Hancock County Ministerial Association.

Educational Provisions of G.I. Bill Liberalized by Congress

Under legislation enacted by the Congress before it recessed for the holidays, provisions of the G.I. Bill of Rights were expanded. Returning medical officers will be especially interested in the new provisions regarding educational benefits.

Under the amended legislation, a returning medical officer planning to enter postgraduate training will be entitled to the following:

1. He can wait four years after his discharge before starting his postgraduate work, instead of two years; he will have nine years after the end of the war to finish his schooling, instead of seven.

2. A veteran of any age will be entitled to educational benefits, based on the number of months in the service. The old law compelled a veteran over 25 to show that his education had been interrupted to become eligible for benefits.

3. The government will pay up to $500 tuition a year regardless of the length of the course of approved schooling. The old provision called for prorating the $500 on a nine-month basis. Now the entire $500 can be paid for short intensive courses, providing the tuition is that much.

4. Subsistence pay for the veteran while taking educational work has been increased from $50 a month to $65, if single; from $75 to $90, if married.

5. Vocational and rehabilitation training had to be completed within six years of the war's end under the old law. Now it is nine years. The limit of such a course was four years. Now it may run longer at the discretion of the Veterans Administration.

6. Living allowance for disabled veterans taking special vocational or rehabilitation training has been increased to $105 in the case of a single man; $115 in the case of a married man.

Those who may be interested in the loan provisions of the new law will find that under the revised act fifty per cent of a loan obtained by a veteran will be guaranteed by the government, up to a total guarantee of $2,000, except in the case of real estate loans when the guarantee will be $4,000. Also, farm loans will not have to be repaid in full for 40 years and home loans in 25 years, instead of 20 years.

The old provision that all benefits received by a veteran under the G.I. Bill would be deducted from any future bonus granted to him has been eliminated.

Xenia—"Advancement of Medicine in the Last Fifty Years", was the subject of an address made by Dr. Reyburn R. McClellan at a meeting of the Spring Hill P.T.A.



In the City of Baqdad lived Hakeem, the Wise One, and many people went to him for counsel, which he gave freely to all, asking nothing in return.

There came to him a young man, who had spent much but got little, and said: "Tell me, Wise One, what shall I do to receive the most for that which I spend?"

Hakeem answered: "A thing that is bought or sold has no value unless it contains that which cannot be bought or sold. Look for the Priceless Ingredient."

"But what is this Priceless Ingredient?" asked the young man.

Spoke then the Wise One: "My son, the Priceless Ingredient of every product in the market-place is the Honor and Integrity of him who makes it. Consider his name before you buy."

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MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

List of Ohio Medical Officers Released From Services Increases; Total Discharged Since V-E Day, 631

DURING the past month, *The Journal* has received information to the effect that 179 additional Ohio physicians have been separated from the services or are on terminal leave, pending discharge.

Including names published in the November and December, 1945, issues of *The Journal*, this makes a total of 631 Ohio physicians reported to *The Journal* as having been released from the services, or on terminal leave, since V-E Day.

In order that The Journal may publish monthly as complete and accurate a list as possible of Ohio medical officers separated from the service, the active cooperation of medical officers themselves, their families and County Medical Society officers, in transmitting such information to the Columbus office of the Ohio State Medical Association, is solicited. Please send the information in promptly, so new names can be added to the list immediately.

Moreover, medical officers are again reminded that the Columbus Office is prepared to supply them with helpful information regarding postgraduate education opportunities and data on opportunities for establishing a practice.

In the following tabulation, the city in which the medical officer resided or practiced when he entered the service is given in most instances. If the physician, after separation, has changed location and this information is known, the place of relocation also is indicated. The rank shown is based on the latest information on file which, of course, may not be up to date in a few cases:

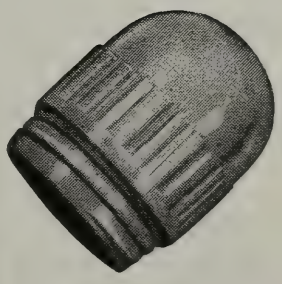
Name	City	Rank
Allard, L. D.	Portsmouth	Major, A.U.S.
Allen, Samuel	East Liverpool	Capt., A.U.S.
Anderson, John B.	Cleveland	Capt., U.S.N.R.
Aronoff, Nathan	Cincinnati	Capt., A.U.S.
Bakos, John	Akron	Capt., A.U.S.
Barber, C. F.	Felicity	Major, A.U.S.
Barker, Harold J.	Cleveland	Major, A.U.S.
Barr, Harry R.	Cleveland	Lt. Comdr., U.S.N.R.
Barr, J. O.	Chagrin Falls	1st Lt., A.U.S.
Bartunek, Robert B.	Cleveland	Major, A.U.S.
Bassett, Garry G.	Cleveland	Capt., A.U.S.
Baube, John L.	Mt. Vernon	Major, A.U.S.
Beach, W. E.	Middlepoint	Col., A.U.S.
Beeman, H. O.	Port Clinton	Capt., A.U.S.
Betts, Thomas F.	Custar (formerly of Findlay)	Capt., A.U.S.
Blackburn, John H.	Columbus	Capt., A.U.S.
Boettner, John F.	Cleveland	Lt. Col., A.U.S.
Bonnell, Geo. H., Jr.	Worthington	Major, A.U.S.
Boyer, Byron E.	Cincinnati	Lt. Col., A.U.S.
Brewer, R. M.	Lebanon	Capt., A.U.S.
Bronson, L. H.	Cleveland	Capt., A.U.S.
Brooks, L. H.	Cleveland	Capt., A.U.S.
Brown, Harry G.	Cincinnati	Major, A.U.S.
Budd, John H.	Cleveland	Capt., A.U.S.
Bunner, D. S.	Columbus	Lt. Comdr., U.S.N.R.
Burgess, Everett C.	Wooster	Capt., A.U.S.
Burroughs, Shepard A.	Ashtabula	Major, A.U.S.
Burstein, Henry A.	Toledo	Lt. Col., A.U.S.
Butner, C. O.	Shiloh	Capt., A.U.S.
Carter, John A.	Middletown	Capt., A.U.S.
Cavanaugh, H. N.	Cincinnati	Lt. Col. A.U.S.
Cellio, Lewis W.	Carrollton	Lt. Col., A.U.S.
Chaikin, Wm. E.	Cleveland	Capt., A.U.S.
Clarke, George E.	Cincinnati	Major, A.U.S.
Cline, Abe	California (formerly of Dayton)	Capt., U.S.N.R.
Cook, Robert G.	Cincinnati	Capt., A.U.S.
Cowan, A. M.	Cleveland	Lt. Col., A.U.S.
Crawford, M. E.	Cleveland	Capt., A.U.S.
Crosby, Harold O.	Findlay	Capt., A.U.S.
Culler, A. M.	Dayton	Capt., U.S.N.R.
Damron, Carl R.	Mansfield	Major, A.U.S.
Daus, Homer J.	Cleveland	Major, A.U.S.
Day, George T.	Cleveland	Lt. Comdr., U.S.N.R.
DeOreo, G. A.	Cleveland	Capt., A.U.S.
DeWitt, Robert M.	Akron	Capt., A.U.S.
Dillahunt, David G.	Columbus	1st Lt., A.U.S.
Donley, R. Frank	Columbus	Major, A.U.S.
Drake, John C.	Mt. Vernon	Lt. Col., A.U.S.
Eberle, William H.	Ashtabula	Capt., A.U.S.
Egli, Edwin B.	Lisbon	Capt., A.U.S.
Eichhorn, John P.	Cleveland	Major, A.U.S.
Eisenberg, Samuel H.	Akron	Major, A.U.S.
Ellery, James A.	Shelby	Capt., A.U.S.
Emery, George M.	Ashland	Major, A.U.S.
Evans, George L.	Mansfield	Major, A.U.S.
Evans, Harrison S.	Columbus	Lt. Col., A.U.S.
Felson, Walter	Greenfield	Capt., A.U.S.
Fisher, Jerome	Columbus	Capt., A.U.S.
Forrester, C. R.	Toledo	Lt. Comdr., U.S.N.R.
Freilich, Myron A.	Zanesville	Major, A.U.S.
Furste, W. L., II	Cincinnati	Capt., A.U.S.
Gates, S. E.	Conneaut	Capt., A.U.S.
Gavin, James A.	Cleveland	1st Lt., A.U.S.
Gibson, Henry H.	Akron	Capt., A.U.S.
Gillespie, Benjamin S.	Senecaville (formerly of Tacoma)	1st Lt., A.U.S.
Gillette, Robert S.	Toledo	Comdr., U.S.N.R.
Good, Charles F.	Cleveland	Lt. Col., A.U.S.
Goodman, David H.	Cleveland	Capt., A.U.S.
Goodman, L. H.	Findlay	Lt. Col., A.U.S.
Greegor, David H.	Columbus	Capt., A.U.S.
Hall, Augustus A.	Columbus	Lt. Col., A.U.S.
Hamilton, Lester A.	Athens	Capt., A.U.S.
Hamilton, William S.	Cincinnati	Lt., U.S.N.R.
Harris, Samuel	Cincinnati	Capt., A.U.S.
Hauser, Chas. U.	Cincinnati	Major, A.U.S.
Haynes, H. A., Jr.	Akron	Lt., U.S.N.R.
Hicks, Warren W.	Columbus	Major, A.U.S.
Hildebrand, R. D.	Newcomerstown	Comdr., U.S.N.R.
Hirst, David L.	Miamisburg	Capt., A.U.S.
Holmes, Nicholas H.	Columbus	Capt., A.U.S.
Hoover, Reuben R.	Columbus	Major, A.U.S.
Horger, William J.	East Liverpool	Major, A.U.S.
Howe, Charles E.	Westerville	Lt. Col., A.U.S.
Huston, Harry R.	Dayton	Capt., U.S.N.R.
Irvin, Emory R.	Bradford	Capt., A.U.S.
Jaffa, Jack I.	Maple Heights	Major, A.U.S.
James, D. S.	Delaware	Major, A.U.S.
Janney, James R.	North Baltimore	Major, A.U.S.
John, Henry J.	Cleveland	Lt. Col. A.U.S.
Johnson, H. H.	Cleveland	Capt., A.U.S.
Kane, Maurice M.	Greenville	Lt. Col., A.U.S.
Karrer, Herman E.	Plain City	Capt., A.U.S.
Kaylor, Fred W.	Bellefontaine	Capt., A.U.S.
Kelly, Fred R.	Cleveland	Lt. Col., A.U.S.
Kohrman, B. M.	Chicago (formerly of Orwell)	Major, A.U.S.
Krasne, Saul I.	Wickliffe	Capt., A.U.S.
Lamb, A. J.	Cleveland	Capt., A.U.S.
Liebow, Irving M.	Cleveland	Major, A.U.S.
Loeb, William J.	Cleveland	Major, A.U.S.
Lohr, L. J.	Dayton	Capt., A.U.S.
Longacre, J. J., IV	Cincinnati	Major, A.U.S.
March, Edgar J., II	Canton	Capt., A.U.S.
Marlowe, Charles	Toledo	Capt., A.U.S.
Matteo, M. L.	Wickliffe	Major, A.U.S.
McAuley, James R.	Perrysburg	Capt., A.U.S.
McKinley, C. E.	Camden	Major, A.U.S.
McWilliam, John M.	Toledo	Capt., A.U.S.
Miller, Thomas S.	Maumee	Capt., A.U.S.
Minder, D. A.	Columbus	Major, A.U.S.
Mitchell, William F.	Columbus	Capt., A.U.S.
Moore, F. T.	Akron	Lt. Col., A.U.S.
Murphy, Howard J.	Toledo	Capt., A.U.S.
Newman, A. P.	Toledo	Capt., A.U.S.
Nichol, A. D.	Cleveland	Lt. Col., A.U.S.
Oliver, William S.	Cleveland (formerly of Middleport)	1st Lt., A.U.S.
Overley, H. Glenn	Loveland	Capt., A.U.S.
Palestrant, M. W.	Continental (formerly of Columbus)	Capt., A.U.S.
Phillips, Clovis H.	Cleveland	Major, A.U.S.
Pitkin, York N.	Cleveland	Lt. Col., A.U.S.



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Preston, Burman H.	Cincinnati	Capt., A.U.S.
Price, Walter S.	Phillipsburg	Lt. Col., A.U.S.
Randell, Asher	Youngstown	Major, A.U.S.
Reading, Paul E.	Painesville	Capt., A.U.S.
Regan, William L.	Wilmington	Capt., A.U.S.
Rehbock, Donald J.	Cleveland	Major, A.U.S.
Reiheld, Robert E.	Waterville (formerly of Loudonville)	Capt., A.U.S.
Reno, Edward C.	Canton	Major, A.U.S.
Repasky, John G.	Akron	Major, A.U.S.
Rhiel, James I.	Eaton	Capt., A.U.S.
Rilling, R. S.	Findlay	Major, A.U.S.
Rosenblum, Earl	Steubenville	Lt. Col., A.U.S.
Rosenblum, Max H.	Steubenville	Major, A.U.S.
Sagebiel, James L.	Dayton	Capt., U.S.N.R.
Salter, H. W.	Cleveland	Comdr., U.S.N.R.
Samson, Ralph B.	Columbus	Surg., U.S.P.H.S.R.
Sawyer, Theodore D.	Crestline	Major, A.U.S.
Scheetz, M. E.	Lima (formerly of Kalida)	Capt., A.U.S.
Schlueter, Simon A.	Akron	Lt. Col., A.U.S.
Schroer, William A.	Fort Loramie	Capt. A.U.S.
Seesholtz, John R.	Toledo	Capt., A.U.S.
Shafer, Charles L.	Mansfield	Lt. Col., A.U.S.
Shapiro, S. J.	Warren	Capt., A.U.S.
Sharon, I. C.	Cincinnati	Capt., A.U.S.
Sharp, H. V.	Akron	Lt. Comdr., U.S.N.R.
Shilling, Harry E.	Troy	Capt., A.U.S.
Simon, Stanley D.	Cincinnati	Major, A.U.S.
Skimming, Louis H.	Middletown	Capt., A.U.S.
Smith, Robert G.	Columbus	Lt. Comdr., U.S.N.R.
Smith, Wayne C.	Van Wert	Capt., A.U.S.
Sohngen, William F.	Cincinnati	Capt., A.U.S.
Speier, Joseph W., Jr.	Cincinnati	Capt., A.U.S.
Solt, Robert L.	Bucyrus	Comdr., U.S.N.R.
Steiner, David L.	Lima	Lt. Comdr., U.S.P.H.S.R.
Strait, John M.	Columbus	Capt., A.U.S.
Surdyk, J. S.	Dayton	Capt., A.U.S.
Switzer, Malcolm E.	Galion	Capt., A.U.S.
Tagett, H. A.	Ashtabula	Lt. Comdr., U.S.N.R.
Ternocky, Frank	Bloomville	Capt., A.U.S.
Thomas, Densmore	Niles	Capt., A.U.S.
Trostel, William W.	Piqua	Major, A.U.S.
Tucker, Harry S.	Cleveland	Major, A.U.S.
Viktoryn, J. W.	Cleveland	Capt., A.U.S.
Vorhies, Gerald E.	Brownwood, Texas (formerly of Scio)	Capt., A.U.S.
Watson, Thomas W.	Wayne	Capt., A.U.S.
Weil, A. M.	Akron	Major, A.U.S.
Weinberg, H. C.	Cleveland	Major, A.U.S.
Weinblatt, Morris	Toledo	Capt., A.U.S.
Wells, J. R.	Akron	Capt., A.U.S.
Wenzinger, Harold J.	Holgate (formerly of Defiance)	Capt., A.U.S.
Wherley, H. F.	Stone Creek (formerly of Coshocton)	Major, A.U.S.
Whitacre, Daniel J.	Columbus	Major, A.U.S.
Williams, J. A.	Cincinnati	Lt. Col., A.U.S.
Wilson, Judson D.	Columbus	Capt., U.S.N.R.
Winter, S. J.	Dayton	Comdr., U.S.N.R.
Wolfe, Clement V.	Jackson, Mississippi (formerly of Columbus)	Capt., A.U.S.
Wright, Jackson W.	Cincinnati	Major, A.U.S.
Yospur, David	Gallipolis	Capt., A.U.S.
Zwick, Louis S.	Wadsworth	Major, A.U.S.

Name Published By Error

In the December, 1945, issue of *The Journal*, the name of Lt. Col. Charles Berns, Cleveland, was published with the names of Ohio physicians released from military service. This information taken from *The Journal of the A.M.A.* was erroneous. Col. Berns has not as yet been released but is on active duty at the Veterans Administration Regional Office, Cleveland.

Cleveland—Dr. Thomas P. Shupe, well-known urologist, has retired from the practice of medicine. He will live in Palm Springs, Calif.

Cincinnati—New officers of the Public Health Federation include: Dr. William J. Graf, president and Dr. Cecil Striker, first vice-president.

Military News Notes

Capt. Peter Volpe, Columbus, now on sick leave from Wakeman General Hospital, Camp Atterbury, Ind., recently was awarded the bronze star for meritorious service as medical corps executive officer with the 76th Armored Medical Battalion.

He received the award for action in France, Luxembourg and Belgium from Dec., 1944, to Feb., 1945, when, according to his citation, "by his courage, technical skill and outstanding devotion to duty he aided materially in the rapid evacuation of casualties and the saving of the lives of many American soldiers."

Capt. Volpe was seriously wounded in action in Belgium on Feb. 4, 1945, when a land mine exploded under a jeep in which he was riding. In service since 1942, he holds the purple heart and wears four battle stars for the Normandy, Northern France, Ardennes and Rhineland battles.

* * *

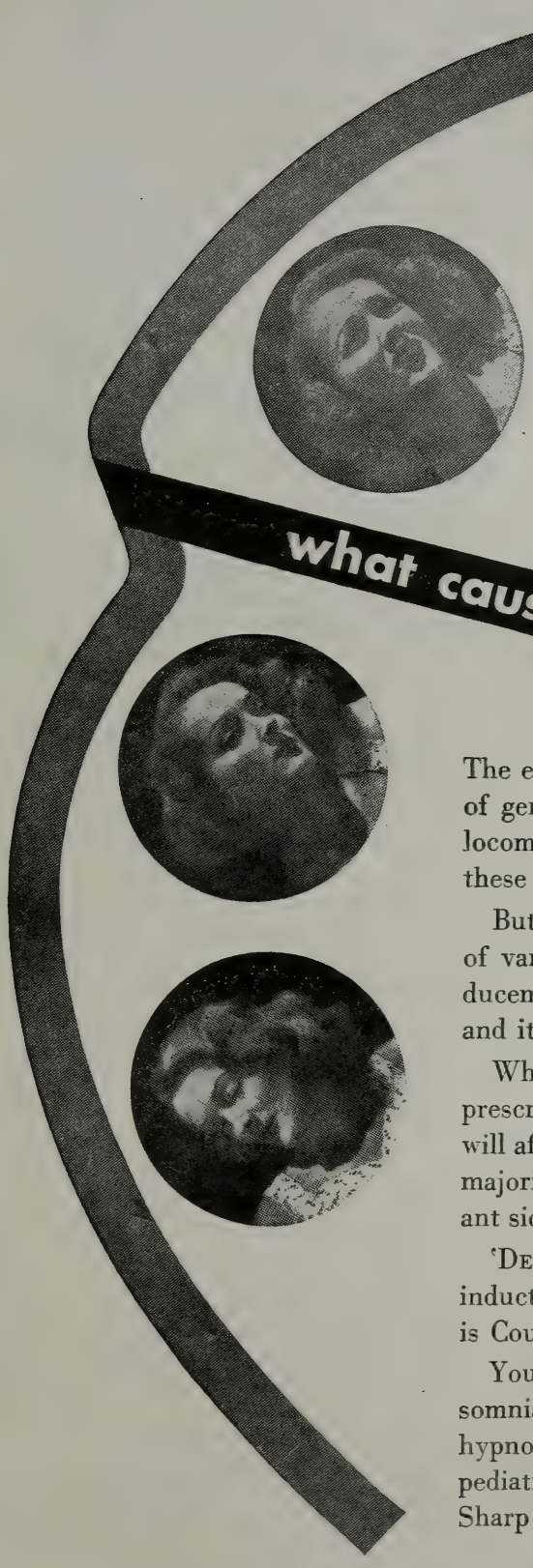
The Legion of Merit has been awarded to Lt. Col. Albert B. Sabin, Cincinnati, "for exceptionally meritorious conduct in the performance of outstanding service in connection with the investigation and control of sandfly fever, dengue fever and Japanese B encephalitis". Associate professor of pediatrics, University of Cincinnati College of Medicine, Dr. Sabin is now home on terminal leave.

* * *

"Back from Bataan", came Maj. Julian M. Goodman, Cleveland, and stopped in at the State Headquarters Office recently to get some information on postgraduate training. A graduate of Ohio State University College of Medicine in 1937, Dr. Goodman entered Army service in Dec., 1940, and was sent to the Philippines. He was captured on Bataan April 8, 1942, and was imprisoned in the Philippines until Nov. 7, 1944. Then packed in the hold of a transport with 500 fellow prisoners, he was fortunate to be on one of the ships in the 21-vessel convoy which was not sunk by American bombs. The trip to the Japanese mainland took 39 days. Approximately 1,700 Americans were lost enroute. Dr. Goodman was liberated on Aug. 14. He is now a patient at Fletcher General Hospital, Cambridge, but expects to be on terminal leave soon. When Dr. Goodman returned to the home of his mother, Mrs. Jule E. Goodman in Cleveland, he found the back issues of *The Ohio State Medical Journal*, which she had saved for him during his internment.

* * *

Changes of address: Capt. Henry C. Beekley, Cincinnati, Reg. Hosp., Chanute Field, Ill.; Capt. Edward J. Geiser, Cheviot, 29th Gen. Hosp., APO 901, San Francisco, Calif.; Capt. Ralph K. Upde-



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WIN PROMOTIONS

Name	City	Rank
Bahrenburg, James H.	Canton	Lt. Col., A.U.S.
Belmont, Morrison H.	Youngstown	Major, A.U.S.
Buckley, C. J.	Cleveland	Capt., U.S.N.R.
Campbell, S. J.	Bucyrus	Major, A.U.S.
Damron, Carl R.	Mansfield	Major, A.U.S.
Eichner, Edward	Cleveland	Lt. Comdr., U.S.N.R.
Elliott, Philip H.	Zanesville	Comdr., U.S.N.R.
Forward, Donald D.	Ashtabula	Lt. Col., A.U.S.
Greene, Norbert S.	Cleveland	Major, A.U.S.
Grimm, Paul E.	Columbus	Lt., U.S.N.R.
Hamilton, I. B.	Canton	Lt. Col., A.U.S.
Helm, Albert J.	London	Capt., A.U.S.
Martin, N. A.	Gallipolis	Lt. Col., A.U.S.
Reed, Howard W.	Akron	Comdr., U.S.N.R.
Reese, Harold J.	Youngstown	Surg., U.S.P.H.S.
Schlueter, Franklin C.	Cincinnati	Capt., A.U.S.
Shaffer, James M.	Dayton	Capt., A.U.S.
Sholl, John G.	Cleveland	Capt., A.U.S.
Staton, Harvey J.	W. Carrollton	Capt., A.U.S.
Strong, J. C., Jr.	Cincinnati	Capt., A.U.S.
Woldman, Victor F.	Cleveland	Comdr., U.S.N.R.
Wolf, Carl J.	Fremont	Major, A.U.S.
Yates, Ralph D.	Piqua	Comdr., U.S.N.R.
Yordy, P. L.	Dayton	Capt., U.S.N.R.

* * *

Capt. William E. Scaggs, Portsmouth, is chief of the surgical service and commanding officer of the Station Hospital, 488th AAF Base Unit, Chico Army Air Field, Chico, Calif.

* * *

The hospital admission peak for malaria relapses in the United States was reached in February, 1945, with a total of approximately 6,000 cases, and has been steadily declining since that time, according to a recent announcement by the Army Medical Department.

During 1943, when men began to return from tropical theaters of operations in increasing numbers, the total number of hospital admissions for malaria relapse reached 5,275. By 1944 it had jumped to almost five times that number—28,150, and in the first six months of this year the total was 30,420.

It is believed, however, that the return of troops from malaria-ridden areas will not appreciably affect the downward trend of admissions, for a large proportion of original personnel already has been replaced and returned. Units and replacements sent to these Pacific-Asiatic regions after the middle of 1943 are not expected to show as high rates of infection as those of earlier groups.

* * *

Major William F. Ashe, Jr., Cincinnati, instructor in medicine and in applied physiology at the University of Cincinnati College of Medicine, has recently been assigned to duty in the European Theater as chief nutrition consultant in the Office of Military Government (U. S.) at Berlin. As chief nutrition consultant on the Staff of Major General M. C. Stayer, Chief of the Public Health and Welfare Branch, Major Ashe will direct the surveys of nutrition of the German civilian population to be made during the coming months.

Before going to Germany, Major Ashe was assistant director, Nutrition Division, Preventive Medicine Service, Office of The Surgeon General. During the past June and July he assisted in a survey of the nutrition of U. S. soldiers in the Philippines and other islands in the Pacific.

* * *

Several Columbus physicians recently returned to private practice after service in the Navy Medical Corps have been promoted to the rank of Captain in the Naval Reserve. They are: Drew L. Davies, William E. Masters, Judson D. Wilson, Henry P. Worstell, Harry M. Sage.

* * *

After 46 months of active duty, Dr. Charles U. Hauser has resumed the practice of orthopedic surgery in Cincinnati. Following service in the orthopedic section of the A.A.F. Regional State Hospital at Langley Field, Va., he was transferred in the Fall of 1944 to the Deshon General Hospital, Butler, Pa., as assistant chief of orthopedics. Maj. Hauser was acting chief during the last few months of his duty there. In June, 1945, he was assigned as chief of orthopedics to the 304th General Hospital, then in training at Fort Knox, Ky. This hospital unit, with four others, went to Tinian in the Mariana Islands in June, where they were scheduled to comprise a 7,500 bed hospital center to handle casualties from the invasion of Japan. With the cessation of hostilities, construction on the center was halted and the units either deactivated or reassigned. Dr. Hauser was transferred to the 148th General Hospital on Saipan. He served as chief of orthopedics there until the latter part of November when he was returned home for separation from active duty.

* * *

Lt. Comdr. Harry E. LeFever, Columbus, has been transferred from the U.S. Naval Hospital, Seattle, to the U.S. Naval Hospital, Philadelphia.

* * *

Capt. Joseph H. Geyer, Columbus, a paratroop doctor, with the 11th Airborne Division, landed on the Atsugi airstrip near Tokyo with Gen.



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MacArthur's honor guard on Aug. 27, 1945, via C54 from Okinawa. His outfit, the 675th A/B Field Artillery Bn., then moved to the Yokohoma Naval Base, thence to Suedai. In the interim he made several jumps on P-W camps, "just a few medics going into isolated camps to start medical aid while the main relief force came by plane and landed at nearby airstrips". At present Capt. Geyer is in Yonesawa, 25 miles south of Yamogata, in the mountains, with plenty snow, and patrols going out by horses wherever possible. He recently made a jump from a reconnaisance plane (L-4) on to a snowy plateau in the mountains to help two aviators forced down by a snowstorm. Dr. Geyer has a few citations, including "a couple of Bronze and Silver Stars". He expects to be in Japan a while longer, "as there just ain't paratroop doctors to replace doctors".

* * *

Maj. Rex H. Wilson, Akron, is commanding officer of the 118th Station Hospital, Sasebo, Japan. The unit acts as headquarters for 17 other medical units located in the area.

* * *

More changes of address: Lt. Henry P. Koehler, Findlay, F.P.O., Navy 128, San Francisco; Lt. Col. Chas. L. Langsam, Macedonia, Midland Heights, Midland, Pa.; 1st Lt. Charles U. Lee, Hamilton, McClosky Gen. Hosp., Temple, Texas; Capt. C. B. Rawers, Steubenville, Army and Navy Gen. Hosp., Hot Springs, Ark.; Capt. James M. Shaffer, Dayton, Northington Gen. Hosp., Tuscaloosa, Ala.; Comdr. Robert G. Lehman, Dayton, U.S. Storm King, (AP 171) c/o F.P.O., San Francisco; Maj. Morrison H. Belmont, Youngstown, 2442 Broadway, San Francisco; Capt. Jack R. Cooper, Columbus, 98th Gen. Hosp., APO 403, New York City; Lt. Col. Ian B. Hamilton, Canton, Army Air Base, Santa Ana, Calif.; Capt. John G. Sholl, Cleveland, Reg. Hosp., Camp Bowie, Texas; Lt. (j.g.) Herman Ulevitch, Cincinnati, U.S.S. Roi (CVE 103), c/o F.P.O., San Francisco; Capt. Franklin M. Schlueter, Cincinnati, 315th Bomb Wing, APO 182, San Francisco.

Cleveland—The Neuropsychiatric Institute of Cleveland has been established at 10528 Park Lane, Cleveland. Its aim is to provide clinical facilities for diagnosis and treatment of patients as well as a research and teaching program. Seminars in neuropsychiatry have been established for physicians of the Veterans Administration in that region and for local practicing physicians.

The staff of the Neuropsychiatric Institute at present consists of Dr. J. L. Fetterman, director; Dr. M. D. Friedman, associate director; Dr. A. A. Weil, research psychiatrist; and Dr. Evelyn Katz, clinical psychologist.

Ohio Division of American Cancer Society Is Re-organized

A code of regulations was adopted and officers and trustees elected at a meeting of the Executive Committee of the recently incorporated Ohio Division, American Cancer Society, Inc., November 18, at Columbus.

The officers are: Dr. E. C. Baker, Youngstown, chairman; Dr. M. M. Zinninger, Cincinnati, vice chairman; Dr. C. A. Wilzbach, Cincinnati, secretary; R. M. Bourne, Cleveland, treasurer; Mrs. Marguerite G. Tremaine, Cleveland, commander.

The officers comprise the Executive Committee and also are members of the Board of the Trustees. Other trustees are: Dr. Charles M. Barrett, Cincinnati; Dr. Chas. A. Doan, Columbus; Dr. Robert L. Faulkner, Cleveland; Dr. R. K. Finley, Dayton; Dr. Farrell T. Gallagher, Lakewood; H. A. Hauxhurst, Cleveland; Dr. Roger E. Heering, Columbus; Dr. C. E. Hufford, Toledo; Dr. Thomas E. Jones, Cleveland; Dr. R. L. Kroesen, Cleveland; Dr. John H. Lazzari, Cleveland; Dr. R. H. Markwith, Akron; Dr. L. A. Pomeroy, Cleveland; Dr. Leon Schiff, Cincinnati; Dr. Robert A. Stack, Lorain; Dr. Edward L. Voke, Akron; Mrs. Whiting Williams, Cleveland. The 22 board members and all officers were elected for one year, until Oct., 1946.

The new executive secretary of the Ohio Division is Miss Hilda McGee, Cleveland, a medical social worker, who has been closely associated with cancer work in Cleveland hospitals. She was also the director of the Social Service Department at Cleveland City Hospital for seven years.

Total contributions to the Ohio campaign from Jan. 1, 1945, to Oct. 31, 1945, were $150,556.91, distributed as follows: County's share, $68,101.48; state's share, $24,883.65; national's share, $57,571.78.

The national goal of the Field Army for 1946 is $12,000,000, with Ohio's quota, $800,000. Of the total amount, 25 per cent is to be ear-marked for research. Fifty per cent of the amount collected in each state will remain there for county projects and 10 per cent in the state for state projects and administrative costs. The national organization plans to spend nine per cent on the development of educational and service materials and six per cent on administrative and campaign expenses.

Cincinnati—Dr. William J. Graf has been re-elected chief of the Bethesda Hospital Staff. Other officers are: Dr. Albert L. Haas, vice-chairman; Dr. A. Harry Crum, secretary-treasurer.

The Preference is Overwhelming

A comprehensive report published in *Human Fertility*[1] shows an overwhelming preference by experienced clinicians for the "Diaphragm and Jelly" method of conception control.

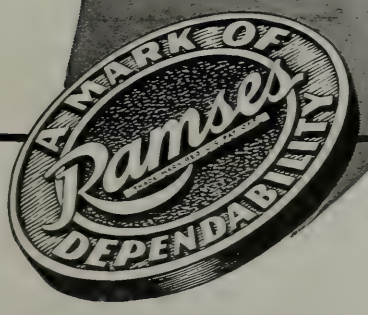
The report covering 36,955 new cases shows that the diaphragm and jelly method was prescribed for 34,314, or 93%.

On the evidence supplied by competent clinicians we continue to suggest that for the optimum in protection the physician should prescribe the combined use of a vaginal diaphragm and spermatocidal jelly.

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History-Making Record of Navy Medical Corps Summarized In Official Report Submitted by Admiral King

"WHEN final statistics are computed on medical care during the war years, there is every indication, upon the basis of preliminary figures, that medical science will be shown to have assumed an importance in the preservation of the health and lives of our fighting men never before equalled in the history of the United States Navy."

Thus is the way Admiral Ernest J. King, commander in chief of the United States Navy, summed up the record made by the Navy Medical Corps during World War II in his final official report to the Secretary of the Navy of recent date.

Other pertinent observations and information submitted by Admiral King on medical and health activities of the Navy will be found in the following excerpts from his report:

"In past wars, disease and infection have caused more deaths and disability in armed forces than actual combat itself. World War I significantly checked this tendency, but the real advantages of modern medical procedures, techniques, and knowledges were experienced during World War II.

RECOVERIES HIGH

"Navy medical statistics show that of the wounded who survived until they could receive medical care, about 98 out of 100 lived. The most recent tabulations indicate an estimated rate for casualty deaths of 8.7 for the first six months of 1945 in terms of total naval strength as against 4.3 per thousand in 1944. This is primarily a reflection of Iwo Jima, Okinawa, and the attacks of the Japanese "kamikaze" pilots. The total death rate from all causes was 6.7 per thousand for 1944 in terms of total naval strength as against 6.0 per thousand in 1943. According to preliminary data the total death rate from all causes for the first six months of 1945 was estimated at 11.9 per thousand. Over-all cases of sickness and injuries, exclusive of battle injuries, were at the rate of 495.4 per thousand average strength in 1944 as against a corresponding figure of 602.8 in 1943.

"Two statistical trends in naval morbidity are worthy of note as indicative of the effect of combat. The first is the average per cent of total strength in hospitals, which increased from 1.7 per thousand in 1941 to 2.1 per thousand in 1944 and 2.5 per thousand for the first six months of 1945. Among other things this shows the effect of the longer convalescent periods required for recovery and rehabilitation of war casualties from such injuries as penetrating wounds and fractured bones. Thus, even though the over-all casualty rate has been maintained at a relatively low figure, the total hospital population has been gradually increasing because of the trend toward a longer average number of sick days per patient.

"The second significant trend was that of mental disease case incidence, which increased from 9.5 per thousand of total naval strength in 1941 to 11.8 per thousand in 1943 and 14.2 per thousand in 1944. These statistics demonstrate clearly the increase in tempo of modern war with its grueling, unfamiliar horrors. This was the motivating factor which has caused the Medical Department of the Navy consistently to emphasize its neuropsychiatric services.

"Statistically the wartime rates indicated above compare favorably with past experience in the Navy, even though the war years have necessitated the maintenance of a large number of naval personnel in foreign waters or on foreign shores where they are subjected to many endemic diseases and infections which are rarely encountered in times of peace.

"Good organization, careful training, and judicious dispersal of medical personnel and supplies made it possible for the Medical Department to meet all demands made upon it in spite of heavy casualties aboard some vessels. These activities included careful classification of the wounded in terms of the urgency of their cases; the use of voluntary crewmen as stretcher bearers, thus releasing hospital corpsmen to assist in caring for the wounded; and the existence of the blood banks aboard many of the vessels making available whole blood for the more serious cases.

ADVANCE BASES IMPORTANT

"The Medical Department's second line of defense after the support given in actual battle areas has been its system of fleet, advance base, base and naval hospitals, its dispensaries, and its hospital ships. Scattered throughout the world, they have provided many thousands of beds and the other medical facilities to give patients complete and definitive care.

"In order to give adequate support to the operational portion of the Medical Department, numerous technical and administrative services have been required. Medical research has been one of these. New drugs, new applications of earlier discoveries, and new techniques have been developed through untiring research and observation. Perhaps the most advertised of these is penicillin, which has been found capable of stopping infection, even where the sulfa drugs are powerless. Prevention and care of burns, use of blood plasma, transportation of whole blood by air to battle areas, and proper

SHOULD VITAMIN D BE GIVEN ONLY TO INFANTS?

VITAMIN D has been so successful in preventing rickets during infancy that there has been little emphasis on continuing its use after the second year.

But now a careful histologic study has been made which reveals a startlingly high incidence of rickets in children 2 to 14 years old. Follis, Jackson, Eliot, and Park* report that postmortem examination of 230 children of this age group showed the total prevalence of rickets to be 46.5%.

Rachitic changes were present as late as the fourteenth year, and the incidence was higher among children dying from acute disease than in those dying of chronic disease.

The authors conclude, "We doubt if slight degrees of rickets, such as we found in many of our children, interfere with health and development, but our studies as a whole afford reason to prolong administration of vitamin D to the age limit of our study, the fourteenth year, and especially indicate the necessity to suspect and to take the necessary measures to guard against rickets in sick children."

*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

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methods for healing fractures are some of the problems receiving attention to the end that the Navy Medical Department will not only stay abreast of the developments in medical science but may maintain its position as a leader.

"Rehabilitation programs for casualties are being conducted at a number of hospital centers scattered throughout the United States. The essential purpose of the program is to develop a clear-cut integrated procedure for the rehabilitation of men for return to duty or to civilian life.

"A second part of the program provides for the close cooperation of the Medical Department with specialized rehabilitation agencies which are designed to assist men to make the necessary adjustments and receive the proper training to fit them for useful employment in civilian life. Considerable emphasis has been placed upon the development of a neuropsychiatric program, and efforts are made by the psychiatrists to reach casualties needing their services as quickly as possible after they are affected, so that permanent injuries are avoided.

"With the coming of peace, the previously prepared plans of the Medical Department for handling the medical aspects of demobilization have been put into effect. Every precaution is being taken to see that the men returned to civilian life are in sound physical condition, particularly in regard to infectious diseases and defects of a serious nature. Those requiring hospitalization, medical or dental attention, are cared for until fit for release, if desired by the individual, or until arrangements have been made for continued treatment outside of the Navy."

Plans Rest After Active Career

Dr. E. Stanton Jones, Painesville, a former secretary of the Lake County Medical Society, has retired from medical practice after a long career specializing in diseases of the chest. Dr. Jones graduated at Ohio State University College of Medicine in 1902. Following ten years in general practice, he served three years at the Cleveland Tuberculosis Sanitarium. Called into the Veterans Administration as a chest specialist, he remained there for 15 years. Dr. Jones did special chest work for three years during World War I, with service at San Antonio, Tex.; Columbia, S. C.; New York City and Camp Merritt. He returned to private practice in Painesville for two years until called back into government service. Dr. Jones was stationed at a large government hospital at Northampton, Mass., for 10 years and in a 2,200-bed veterans' hospital on Long Island for two years. Upon his retirement from the Veterans Administration in 1940, he resumed practice in Painesville. Dr. Jones plans to rest and relax in Florida.

Interested In Luncheon Session of N. and M. Section?

If a sufficient number of doctors are interested, the Section on Nervous and Mental Diseases of the Ohio State Medical Association will arrange for a luncheon Wednesday noon, May 8, during the 1946 Annual Meeting of the State Association in Columbus, May 7, 8 and 9.

The regular session of the section will be held on Thursday morning, May 9. However, the section officers believe that physicians interested in this field might wish to have an informal luncheon gathering on the preceding day. Efforts would be made to have a guest speaker. The luncheon would end in time for all to attend the General Session on Wednesday afternoon.

Those interested in this idea should write immediately to either Dr. J. M. Wittenbrook, 3005 Yorkshire Road, Cleveland Heights, the section chairman, or to Dr. E. H. Crawfis, Cleveland State Hospital, Cleveland 5, the section secretary.

Psychiatric Placement Service

The American Psychiatric Association and the National Committee for Mental Hygiene jointly announce the appointment of Captain Forrest M. Harrison (MC), U. S. N., as director of a newly established Psychiatric Personnel Placement Service. The service is designed especially to help physicians and psychiatrists make contacts with training opportunities and to aid institutions in locating suitable candidates for appointments. Physicians interested in psychiatry are invited to send in full biographical statements. Deans of medical schools, superintendents of hospitals, and directors of industrial organizations, clinics and others employing or participating in the training of psychiatric personnel, are invited to submit full information regarding available positions and courses, including financial details.

Foundations, universities and other agencies are asked to report pertinent fellowships in psychiatry, psychosomatic medicine and child guidance.

Inquiries should be addressed to Captain Forrest M. Harrison (MC) USN, National Committee for Mental Hygiene, 1790 Broadway, New York City 19.

Galion—Dr. Jonathan Forman, Columbus, spoke on "Mineral and Vitamin Deficiencies", at a recent meeting in the Senior High School Building.

Why Do People Use Cosmetics?

Isn't it because they wish to improve their appearance?

Why do people wish to improve their appearance? Isn't it because they have a natural desire to be as physically attractive as possible, both to satisfy their self-respect and to please those with whom they come in contact?

In the Federal Food, Drug, and Cosmetic Act, the term "cosmetic" is defined as, "(1) Articles intended to be rubbed, poured, sprinkled or sprayed on, introduced into, or otherwise applied to the human body or any part thereof for cleansing, beautifying, promoting attractiveness, or altering the appearance. . . ."

From this definition it is obvious that the chief functions of cosmetics are to cleanse and to improve the appearance, to beautify.

Cleanliness may be said to be the foundation of a lovely appearance. We are sure you will agree that the fundamental reason why people use cosmetics is to improve their appearance, to look lovelier.

It has been said that the function of a cosmetic is to encourage the normal physiology of the skin, not to change it. Cosmetics improve the appearance of the skin; they do not in our opinion change its physiology, which is to say its normal functioning, structure and individual characeristics.

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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

STRAWS IN THE WIND IN 1946

One Washington commentator who hits the bull's eye oftener than not, had this to predict regarding the Truman national health program: "Part of it will be enacted next year (1946) . . . building of hospitals, public health extension . . . medical education, etc. . . . but the **controversial feature,** the public fund for paying doctor bills, probably **will be put off for a year. Still, the idea is making progress . . .** Social security expansion will be pushed hard early next year but we think Congress will not vote any great sweeping changes in '46 . . . "

Child Welfare League of America, Inc., headed by Leonard W. Mayo, school of social science, Western Reserve University, in addition to plugging for enactment of the Pepper maternal and child health bill, is advocating a Federal department of welfare, with cabinet status, to run all Federal welfare, health and educational services . . . **Health should stand on its own feet, in our opinion . . .**

C. I. O. Political Action Committee plans meetings in 38 states while Congressmen are on holiday vacation, to apply pressure on legislative matters . . . probably including health legislation . . . Which reminds us: Have you talked with **YOUR CONGRESSMAN?** He'll be home for a few weeks . . . look him up . . . the C. I. O. doorbell ringers are . . .

Republican brass hats are laying plans to concentrate on the 1946 Congressional elections—primaries in the Spring . . . elections in the Fall . . . These may prove to be the most crucial elections in the nation's history . . . doctors as citizens and **AS DOCTORS** will have a big stake in the results . . . keep your eye on the candidates . . .

Incidentally, did you read the policy statement issued recently by Senate and House Republicans and which may be the basis for the 1946 election platform? . . . Here's one section of special interest: "We favor Federal aid to the extent necessary, to states and through states to subdivisions, to assist them in affording subsistence, shelter and medical care to their citizens who are unable to provide for themselves . . . Such aid including unemployment compensation must be based on state and local initiative, operation and responsibility, without Federal bureaucratic interference. **We must avoid socialization of the medical profession or any other activity . . . "**

By the way, when you talk to your Congressman, **tell him about Ohio Medical Indemnity,** Inc., . . . the "doctors' plan" . . . It is a concrete answer to the questions: "How can people budget on an insurance basis for the costs of medical care?" . . . "How can it be done without political control?" . . . "What are the doctors doing about it?" . . .

It can be a happy and prosperous New Year . . . but it won't come the easy way . . . **if American ideals are worth preserving, they're worth fighting for, on the home front as well as abroad** . . . How much fighting are **YOU** willing to do?

A BOOST FOR OHIO MEDICAL INDEMNITY, INC.

Congratulations to the editorial writer of *The Cincinnati Enquirer* who wrote the following editorial for the December 10 issue of that newspaper regarding the inauguration of the activities of Ohio Medical Indemnity, Inc., (although not mentioned specifically) in Southwestern Ohio, supplemented with some pertinent comments as to why the voluntary way—the "doctors' plan"—offers definite advantages over the recommendations of the social planners:

Paying for Health

For the last five years the State of Michigan has had a practical prepayment plan for the costs of medical care. It now covers almost 1,000,000 people in Michigan, and is growing rapidly. Through payroll deductions, on much the same basis as the Hospital Care plan familiar to Ohioans, Michigan citizens can pay a modest fee each month, which covers any expenses they may have for surgery, obstetrics and some other major items of medical care. It is a simple, efficient plan.

In Cincinnati and indeed in numerous counties of Southwestern Ohio, a similar plan will be undertaken in a few weeks. It will then be possible for any employed person, and for most others, to insure himself and his family against the large doctor bills that loom as an unpredictable hazard in every family. The plan now ready for launching will be open to all who subscribe to Hospital Care under the Blue Cross plan—which means 40 per cent of the population of this area at present. It will cost only a dollar or two a month. It will compensate the subscriber for any surgery, obstetrics, or treatment of fractures, approximately the sum of his own doctor's bill. The project was undertaken by the physicians of Ohio, on their own initiative, with their own resources. It is a nonprofit venture, closely linked with the Blue Cross plan for hospitalization.

Between the two programs, almost any individual will be able to assure himself of adequate medical and hospital care, paying a modest sum each month. He will choose his own doctor, his own hospital. He will not have to stand in line

Doctor—Judge

PHILIP MORRIS suggests *you* judge . . . from the evidence of your own *personal* observations . . . the value of PHILIP MORRIS Cigarettes to your patients with sensitive throats.

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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154.*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60.

TO THE DOCTOR WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

while a bureaucratic officer of the Social Security Administration considers his problem.

This program of prepaying the cost of medical and hospital care is more efficient, more economical and covers all sections of the United States, and to reach all but the families with no income or very small incomes. By Federal payment of the fees of indigent families, it can be made to serve the whole population. This spontaneously developing plan for medical and hospital care ought to be studied thoroughly before any reckless step is taken in Congress to nationalize the financing of medical care.

CARELESS DOCTORS AID NARCOTIC PEDDLERS

George J. Gary, head of the Cleveland bureau of narcotics, has issued a warning to physicians that narcotic licenses may be revoked in cases where carelessness on the part of the physician is an element in narcotic thefts. The warning was issued after a survey of police records showed more than 100 thefts of physicians' cases containing narcotics from automobiles in the Cleveland area alone during recent months.

Physicians are obligated to assist officials in attempting to control the activities of narcotic rings by seeing that cases containing narcotics are not left in automobiles or elsewhere where they are easy loot for smugglers and peddlers.

SERVICE MEN'S GROUPS COUNTING ON DOCTORS

When Maj. Gen. Paul Hawley, medical director of the Veterans Administration, addressed the Conference of County Society Presidents and Secretaries sponsored by the Ohio State Medical Association last November 11, an official representative of the American Legion of Ohio was present as a guest of the Association.

Commenting on General Hawley's remarks in the *Ohio American Legion News,* Mr. Harvey C. Cheney, Legion Service Director, summarized as follows:

"His approach to the problems, his frankness in sizing up the situation and the results of the delays that have been incident to the formation of plans, is refreshing. The interest which he is able to arouse everywhere, but especially among the medical profession and the evident desire of the medical men to find out what they can do, should result in a much better understanding of the problems involved, both from the point of view of the veteran and the requirements of the Administration.

"Gen. Hawley is only a temporary assignment to the Veterans Administration. It is hoped that his recall to the Army will be sufficiently delayed to permit him to make a complete job of the changes which he has started."

Mr. Cheney's observations are significant They show that those organizations which are deeply concerned in seeing that the Veterans Administration is converted into an efficiently functioning agency are counting strongly on the cooperation and support of the medical profession. More than that, they are expecting the medical profession to take the lead on medical and health phases of the V. A. program.

The medical profession of Ohio is not going to sidestep this great responsibility, we are sure.

What plans are being made by your County Medical Society?

Bring up the question for discussion at the next meeting of your society. Get a committee appointed and working. The State Association has one and in the near future it will be ready to serve in an advisory capacity.

WHICH? MASS SOCIAL AID OR DEMOCRACY?

Speaking of security, social aid, etc., Bishop Michael J. Ready of the Columbus Catholic Diocese in an address before the recent Ohio Welfare Conference offered some words of wisdom which warrant far more than casual consideration.

Warning that social aid in itself can never be an ultimate goal and that too much of it may lead to the suicide of democracy, Bishop Ready said:

"The power of environment and the mass over the individual can be used in ways which are injurious to personal integrity, freedom and responsibility, and creating increased dependency, insecurity, fear and confusion.

"Social aid—whether by Federal or state legislation, by government, community, or private agency, or by personal service—can never be seen as the ultimate goal.

"To increase the individual's dependency on the group is ultimately to further fears and insecurity and to add to the already too numerous class of the irresponsible members of society.

"Certainly such loss of the sense of responsibility and personal integrity in the individual citizen is the suicide of true democracy and a tragedy for all human society. There is the grave danger of mass predominating over the individual's rights to independence and self-determination if techniques are not cautiously curbed and wisely controlled."

Let those who see in suggestions like the so-called Truman health program the millennium in health, ponder these words.

Also, let them think over the comments of Dr. Martha Eliot of the U. S. Children's Bureau on the progress which has been made in reducing maternal and infant death rates during the decade 1933-1943. Said Dr. Eliot:

"Improvement in the economic status of many families is also an important factor. Many women have been able to have a better diet during pregnancy, and the diet of the mother affects her child's well-being as well as her own. More women were able to have their babies in hospitals, and hospitals are the safest place for a baby to be born."

Those who believe a regimented, politically-controlled maternal and child health program will



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be the answer to the ills of more than half the population, i. e., the so-called Pepper Bill, should heed Dr. Eliot's observations.

There is no easy road to security, including health. Europe found out that.

WHAT PRICE SECURITY?

Writing in *The Journal of the A.M.A.* regarding the need for physicians in state and local health departments, Surgeon General Thomas Parran made the following statement, the wisdom of which is doubted:

"In the military services, approximately 60,000 physicians have been experiencing the financial security of a fixed salary. A similar security is offered in most public health positions."

Security may be—and is—important but we wonder how many of those who went through the recent experience in the Army and Navy will want to trade what they gave up for the security of a "fixed salary".

Physicians are needed to man public health departments, we agree, but Dr. Parran will have to think up a better argument than the above to lure very many ex-service men into that service, in our opinion.

BEING "DOC" ON MAIN STREET HAS ITS ADVANTAGES

Fortunately, a considerable number of young medics now being released from the armed forces and seeking places to locate for practice are not overlooking the possibilities offered by the rural areas in Ohio.

They are looking at the situation in a realistic manner. Some of them have done a good job of balancing the advantages against the disadvantages; weighing the stress and strain of high-geared competitive practice in the city against the more quiet life in the country where living expenses are lower, social life more intimate, one can have a garden and chickens, maybe a pig or two, and patients are known as John Smith and Mary Jones instead of Case X or Case Y, perhaps.

True enough, plenty has to be done to make rural practice and life in the little town more attractive for the doctor—especially if he has a city-bred wife. But, the day when rural practice will be sought after instead of shunned is not far off. Farm groups are actively working on improvement of the social and economic conditions in rural areas which, of course, is fundamental. Moreover, the movement to provide outlying districts with the advantages of a hospital, diagnostic facilities, etc., is gaining momentum.

We can think of a considerable number of so-called country doctors in Ohio who are sitting on top of the world and wouldn't trade positions with any city specialist anywhere.

The boys coming home who are giving more than a hasty glance at some of the areas where the good folks would welcome them with open arms and see that they get off to a real start are playing it smart, in our opinion.

Being just plain "Doc" on Main Street has its advantages. If you don't believe it, ask one.

START NOW POLISHING UP THE BRASS KNUCKLES

When Messrs. Wagner, Murray and Dingell introduced proposed legislation to make President Truman's national health program effective (S. 1606 and H.R. 4730), a neat bit of parliamentary strategy was used in an effort to get the bills in the hands of "friendly" committees, according to some Washington observers.

When the bills were written, tax provisions were excluded. They will simply establish a program, if enacted, and authorize future Congresses to appropriate sufficient funds to finance the benefits.

Because of this the sponsors were able to get S. 1606 referred to the Senate Committee on Education and Labor, of which Senator Murray is chairman. In the House, Mr. Dingell was able to get H.R. 4730 referred to the Committee on Interstate and Foreign Commerce, subsequently to a sub-committee on public health.

Time alone will produce the answer as to whether these committees are as "friendly" as the sponsors of the bills believe them to be. Perhaps, they will find the bugs in the proposals quicker than some may think at the moment.

Nevertheless, had the measures contained tax provisions it is quite likely they would have been referred, under standing rules, to the Senate Finance Committee and the House Ways and Means Committee. In the past compulsory sickness insurance measures have been considered by these committees which have always expressed a doubtful attitude toward legislation of this kind and similar measures calling for huge government expenditures and increased taxation at this time.

Thus we have a little picture of the tactics which are being used, and will continue to be used, by those who are determined to nationalize medical services.

Those who realize the dangers in such a program might just as well start now polishing up their brass knuckles.

Dr. John D. O'Brien, Canton, and Miss Virginia Wing, executive secretary of the Cleveland Anti-Tuberculosis League, have been named to the Advisory Council of the State Mental Hygiene Division, by Frazier Reams, State Welfare Director.

Want better protection . . .

. . . Policy coverage is no better than the service by which it is administered.

for greater malpractice hazards? . . .

. . . Prevailing unrest multiplies the dangers in every doctor's practice. His protection should therefore be more than good.

Use Specialized Service!

. . . Even if all policies were the same, Specialized Service would still put the "plus" in Medical Protective.

The Medical Protective Company

of

Fort Wayne, Indiana

How the Medical Care Program of the American Medical Association Can Be Made Effective in Each Community

BY LOUIS H. BAUER, M.D., HEMPSTEAD, N.Y.

Editor's Note: On June 22, 1945, the American Medical Association issued a revised 14-point constructive "Program for Medical Care". Naturally, action by state and local medical societies and individual physicians will be necessary to make the program effective. How this may be done by societies and individual physicians was outlined in detail by Dr. Louis H. Bauer, member of the Board of Trustees of the American Medical Association, in an article published in the December 1, 1945, issue of The Journal of the American Medical Association. The article is republished in these columns for the sake of emphasis and with the admonition that every member of the Ohio State Medical Association make himself a committee of one responsible for seeing that the recommendations made are carried out in his community.

WE are concerned with a problem on which there are sharp differences of opinion. In fact, were there not these differences of opinion there would be no problem.

As to the ultimate aim we are all agreed. I believe no one can quarrel with the platform of the American Medical Association, adopted in June, 1944, which calls for "availability of medical care of a high quality to every person in the United States". The differences of opinion arise as to how this aim is to be achieved.

As doctors we see the problem in a way no one else can possibly see it. It pertains to our daily work and we are naturally closer to it than any one else. One does not consult a doctor if one wishes to draw up a will. One goes to a lawyer. Neither does one consult a lawyer if one wishes to build a house. One goes to an architect. Yet there are many who think it is not necessary to consult the doctors on any problems related to medical care but that legislators, those engaged in social welfare and other laymen can draw up a complete program, have it adopted and then expect the doctors to make it work. It should be borne in mind that, no matter what system is eventually evolved in this country for delivering medical care, the doctor is the one who is going to have to deliver it. It can not possibly be delivered by a "social uplifter". Hence it would be better for all concerned if the plan adopted is one which will enlist the cooperation and enthusiasm of the medical profession.

Another point usually lost sight of is that the mere delivery of a quantity of medical care is not solving the problem. The homeopathic precept that the more a thing is diluted the greater its effectiveness went into the discard long ago. What we want is not just more medical care but more medical care of a high quality.

ANSWER IS COMPLEX

The answer to any complex problem is usually not simple but also complex. So, in our problem of medical care, the answer is not a single one but a multiple one. Yet the Social Security Board and Senators Wagner and Murray and Congressman Dingell refuse to admit there is any possible answer but the single one of a national compulsory sickness insurance, regardless of the fact that nowhere has it been as satisfactory as our own system of private medical care.

A careful analysis of the situation would seem to indicate that there are certain elemental factors which are responsible for our problem. These factors are (1) improper distribution of doctors, (2) lack of proper diagnostic facilities in certain areas, (3) the costs of illness—particularly so-called catastrophic illness—and (4) a general economic factor. These factors are closely related and can not be considered separately. Why are certain areas devoid or short of doctors? There are two reasons. One is that certain areas are so sparsely settled that there is no attraction for a doctor, not only because he will have insufficient patients, but because there are no educational or social facilities for him to bring up his children. The other is really the second factor (namely, the lack of proper diagnostic facilities) so that he can not practice good medicine. In the latter case he either leaves and goes elsewhere or else he does what to my mind is worse, he stays and practices poor medicine. With further reference to the lack of diagnostic facilities, this lack is usually because the community by itself can not support the necessary facilities.

AVAILABILITY OF FACILITIES

The third factor, the costs of illness, again is tied up partially with the second: availability or nonavailability of proper diagnostic facilities. The high cost of illness is not in ordinary intercurrent illness but in the cost of diagnosis in the more complicated illnesses, in hospitalization and in private nursing care. Also in sparsely settled areas the long distances a doctor may have to go increase the cost of his services. Still

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another important reason is the cost of care of the chronic invalid.

The fourth factor—the general economic one—is the matter of housing, clothing, nutrition and sanitation. This is a social problem of the community and not a medical problem, although the neglect of it results in an increase in the prevalence of disease and the necessity for medical care. The solution, however, is not the pouring in of medical care but preventing the necessity for it.

With this as a general background, let us now see how the American Medical Association proposes to solve this problem. On June 22, 1945, the Board of Trustees and the Council on Medical Service and Public Relations of the Association adopted jointly a fourteen-point constructive Program for Medical Care.

This program is as follows:

PREAMBLE

The physicians of the United States are interested in extending to all people in all communities the best possible medical care. The Constitution of the United States, the Bill of Rights and the "American Way of Life" are diametrically opposed to regimentation or any form of totalitarianism. According to available evidence in surveys, most of the American people are not interested in testing in the United States experiments in medical care which have already failed in regimented countries.

The physicians of the United States, through the American Medical Association, have stressed repeatedly the necessity for extending to all corners of this great country the availability of aids for diagnosis and treatment, so that dependency will be minimized and independence will be stimulated. American private enterprise has won and is winning the greatest war in the world's history. Private enterprise and initiative manifested through research may conquer cancer, arthritis and other as yet unconquered scourges of mankind. Science, as history well demonstrates, prospers best when free and unshackled.

PROGRAM

The physicians represented by the American Medical Association propose the following constructive program for the extension of improved health and medical care to all the people:

1. Sustained production leading to better living conditions with improved housing, nutrition and sanitation, which are fundamental to good health; we support progressive action toward achieving these objectives.

In this connection the American Medical Association has previously stated that "it is not in the public interest that the removal of economic barriers to medical science should be utilized as a subterfuge to overrun the whole order of medical practice. Removal of economic barriers should be an object in itself." To illustrate this point, there appeared in a popular magazine a few years ago a drawing showing a woman in a state of malnutrition, clad in rags, surrounded by children also undernourished, likewise clad in rags, standing before a hovel. The picture had as its topic "These people need medical care." Of course they needed medical care, but had they been properly housed, fed and clothed they probably would have needed very little. Yet this picture was used as propaganda to call for a new system of medical care, whereas the fault was not primarily medical but a social fault of their community.

Prevention of disease by inoculation and curing disease in its early stages are excellent, but it must be remembered that good living conditions, including good nutrition, housing and sanitation, are equally important. We have as a shining example of this the condition of some of our prisoners of war, who were released not only in a state of malnutrition but often afflicted with deficiency diseases such as beriberi, diseases influenced by overcrowding such as tuberculosis and diseases due to cold and damp such as arthritis and rheumatic conditions. Again, faulty sanitation may be the main factor in the spread of typhoid, overcrowding and lack of cleanliness in the spread of typhus. The mere provision of a quantity of medical care does not affect the cause of these diseases. The real cause is often economic and not medical.

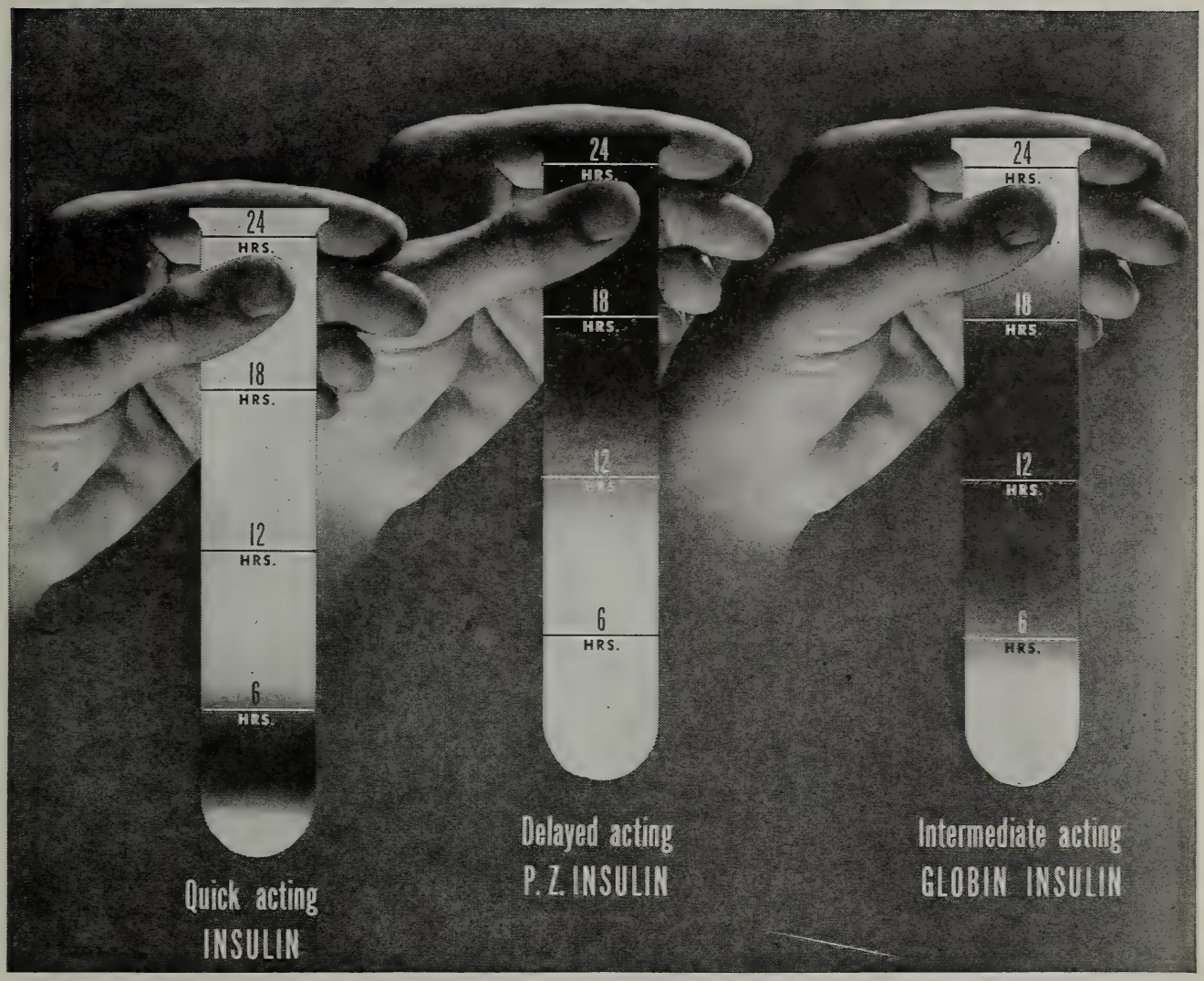
The implementing of this first point must be by education of the public. There are constant attempts to overthrow the whole order of medical practice on the theory that the people in this low economic group have inadequate medical care, whereas the solution is in raising the economic level of these people.

Constant publicity is recommended on the facts of this particular problem through the American Medical Association, the state associations, the county societies and the women's auxiliaries, by addresses and articles not only in the medical journals but also in the lay press.

2. An extended program of disease prevention with the development or extension of organizations for public health service so that every part of our country will have such service, as rapidly as adequate personnel can be trained.

Not over half of the counties in the United States have a full-time public health service. In some cases where a full-time service does exist, it is subject to political control, there is no continuity in administration and an inefficient health department results. Now it would not be feasible for every county to have a full-time health department of its own because of the expense. However, neighboring counties could form a district health department with a traveling health service and laboratory. The protection of the water, milk and food supplies, proper sewage disposal and mosquito and fly control will prac-

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tically eliminate many diseases with not only no increase but an actual decrease in the amount of medical care necessary. To do this public support must be secured and in some instances funds from outside the community must be obtained. The medical profession has no objection to the use of Federal funds where necessary to establish health departments but believes that the administration of these activities should be under local control, except as to meeting general high standards.

Training of public health officials is important, and when they are trained they should be adequately compensated. At present many public health officials do not receive the income of men engaged in private activities or often in other fields of government.

The implementing of this second point is by means of legislation. Such legislation should also be of interest to the American Public Health Association, the State and Territorial Health Officers Association and the U. S. Public Health Service. It is recommended that the American Medical Association sponsor a conference with these groups in an endeavor to enlist their cooperation in legislative efforts to accomplish the purpose of this item.

3. Increased hospitalization insurance on a voluntary basis.

4. The development in or extension to all localities of voluntary sickness insurance plans and provision for the extension of these plans to the needy under the principles already established by the American Medical Association.

5. The provision of hospitalization and medical care to the indigent by local authorities under voluntary hospital and sickness insurance plans.

These three may be considered together. At present over 19,000,000 people are insured under Blue Cross hospitalization plans and about an equal number are insured through their industries, although there are probably many duplications so that the total is not twice 19,000,000. This method has grown rapidly and tremendously and seems to meet the needs for hospitalization where it is in operation. It would seem, therefore, that extension of this insurance on a voluntary basis so that it is available to every one who desires it should be our aim and that every support should be given it.

Voluntary sickness plans now cover nearly 29,000,000 persons in the United States. The plans vary. Some are industrial, some are medical society sponsored and some are private insurance in commercial companies. The plans also vary as to coverage. Some give complete coverage and others give only partial coverage. Some cover only the employee and others his family as well.

Except for a few industrial plans, the idea is comparatively new. When it was started it was deemed best to begin on an experimental basis in small areas. No one knew what coverage should be given; there was no actuarial background and no one knew how either the public or the profession would react to it. Consequently, progress has been slow. Many plans were abandoned and others revised. Ideas are now crystallizing as to the best type of plan or, rather, plans, as no one plan seems to be suited to every area and every class. By that I mean that what will work in New York City will not necessarily work in Topeka, Kans. Rural and agricultural needs are different from metropolitan and industrial. However, certain elements in these plans may be workable nationally, and efforts are being made to establish national indemnity plans.

The American Medical Association would extend these voluntary plans and has approved the principle of so-called medical service plans for the medically indigent. To show how these matters progress, the original approval of voluntary medical insurance was on an indemnity basis only. Now both are approved so long as they follow certain principles.

The American Medical Association also has recommended the use of the voluntary insurance principle in the hospitalization as well as the medical care of the indigent. Public authorities could make use of these plans wherever they are available at a lower cost and with more efficient service than by extending institutions for the indigent or employing full time physicians to care for the indigent. Some of those who desire compulsory sickness insurance say this can not be done because the law does not permit it, but I note that they have no hesitation in urging changing of the law to permit compulsory sickness insurance, which the law does not permit now either.

Since there will be a special report on this subject, it is recommended that any decisions on this subject be integrated into the implementation of these three points of the program.

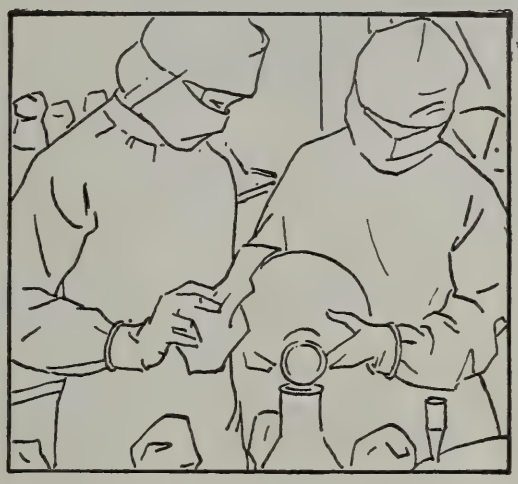
In addition, it is recommended that the medical care of veterans be integrated into these voluntary plans of hospitalization and medical care. This large group would help stabilize these plans and at the same time give the veterans free choice of physician and permit them to be cared for on a local basis without the necessity of vast extension of government institutions.

6. A survey of each state by qualified individuals and agencies to establish the need for additional medical care.

The scientific approach to the problem is to determine the needs first and then to treat spe-

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cifically the needs that are so developed. It is important to have a survey in every state to find where the weakness lies—whether in the field of infant mortality, venereal disease, tuberculosis, lack of hospital beds, lack of diagnostic facilities or elsewhere—and then to take steps necessary to meet those needs.

These surveys should include every medical facility, not just certain ones, as no true picture can be obtained of any facility without considering the problem as a whole and with due reference to every factor.

These surveys should be made by the state agencies, public and private, with cooperation and approval of the state medical associations.

7. Federal aid to states where definite need is demonstrated, to be administered by the proper local agencies of the states involved with the help and advice of the medical profession.

The medical profession, under certain conditions, approves appropriations by Congress of funds for medical purposes. It feels, however, that in many instances states have sought aid and appropriations for such functions without any actual financial need on the part of the state, in order to secure such funds as might be available. Funds may be allotted when proof is given of the actual financial need by the state for prevention of disease, for promotion of health or for the care of the sick. Health is primarily a local responsibility. Physicians should be integrated into the control of all medical affairs, and the control of local projects should be local in character.

This likewise is a legislative matter and should be implemented by the Americal Medical Association again, in collaboration with the other agencies listed under item 2, together with the collaboration of the state medical associations.

8. Extension of information on these plans to all the people with recognition that such voluntary programs need not involve increased taxation.

One of the difficulties we encounter is that the people do not realize the vast amount of medical service now available. In every large city and in many counties and states there are extensive provisions for medical service, of which those entitled do not avail themselves. Education of the public as to what is available and how to obtain it is essential. The Medical Society of the State of New Jersey a few years ago broadcast to the public via the press, radio and public speakers that any person in the state of New Jersey who could not get medical care should immediately contact the state society. Out of the entire population of New Jersey only seven persons applied, and in each of these seven cases medical care was available. They simply did not know how to obtain it.

This is again a purely educational matter, and the implementation should be through the American Medical Association, the state associations, the county societies, the woman's auxiliary and the appropriate voluntary health agencies. The bulk of the information necessary is, of course, local and hence the educational activities must be necessarily largely local.

9. A continuous survey of all voluntary plans for hospitalization and illness to determine their adequacy in meeting needs and maintaining continuous improvement in quality of medical service.

Exactly as a preliminary survey is needed to determine the areas of need, so also must there be continuous surveys of the manner in which existing provisions meet existing needs in order to permit progress. There should be continuous evaluation of medical services so that they may be kept up to the best that can be provided.

We will now consider items 10, 11, 13 and 14 together, as they are related and pertain to the emergency, the result of the war.

10. Discharge of physicians from the armed services as rapidly as is consistent with the war effort in order to facilitate redistribution and relocation of physicians in areas needing physicians.

11. Increased availability of medical education to young men and women to provide a greater number of physicians for rural areas.

13. Adoption of Federal legislation to provide for adjustments in draft regulation which will permit students to prepare for and continue the study of medicine.

14. Study of postwar medical presonnel requirements with special reference to the needs of the veterans' hospitals, the regular army, navy and United States Public Health Service.

Some 60,000 physicians have entered the armed forces voluntarily to do their part in the war. Discharge of these physicians as rapidly as possible is essential, to relieve areas where there is an insufficient number of physicians to care for the civilian population and to facilitate redistribution and relocation of physicians in areas requiring them. The American Medical Association has established a Bureau of Information to determine such areas of need and to facilitate relocation of physicians.

The present draft regulations ignore the necessity of providing students for necessary premedical study. The United States is the only country

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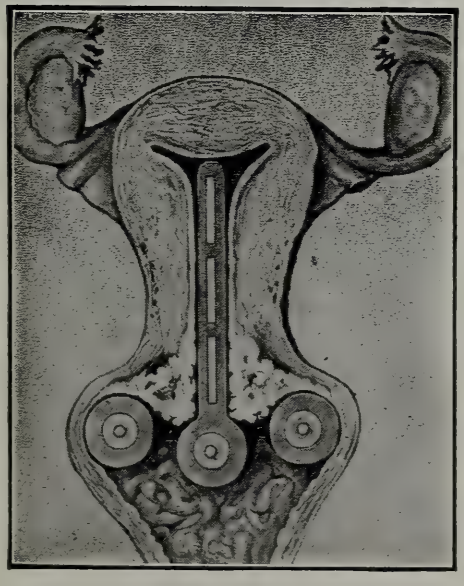
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that has not protected the training of individuals for medicine and other sciences. Unless steps are taken to remedy this situation there will be an increasing shortage of physicians in the near future. Any legislation for compulsory military service should recognize the need for maintaining continuous training in science and particularly in the science of medicine.

Item 14 ties in with this, as there will be a greatly increased call for physicians during the next few years to meet the needs of an increased regular army, regular navy, Veterans Bureau and occupied territory. Not only shall we need more physicians, but care must be taken to see that only the physicians actually necessary are taken into the services. There are many complaints that physicians in the services are in excess of what is required and that their professional skill is not properly utilized. This may have been necessary or unavoidable in war but certainly is not in peace.

Item 11 is closely related to the three preceding items. Medical schools have suffered during the war from a lack of properly qualified persons to take the courses. The removal of premedical students from the colleges by the Selective Service System is chiefly responsible. The American Medical Association advocates every possible effort toward filling the classes of the premedical students and toward expanding medical education to meet the needs of the nation. To attract physicians to rural areas there must be adequate diagnostic facilities, and in some cases subsidies may be necessary.

To implement these items, the American Medical Association should continue its close contact with the Army and Navy and continue urging that physicians be released as rapidly as possible and, further, that the existence and functions of the Bureau of Information be steadily advertised to the men in the services.

Pressure should also be continued on the responsible authorities by both the American Medical Association and the state medical associations to effect the recommended changes in the draft regulations, and if this fails legislation should be sponsored to bring about these changes.

With reference to item 11, *this is in part related to the establishment of adequate diagnostic facilities so that there will be attractions for the physician in rural areas. While the training of more physicians is necessary, this is no surety that when they are trained they will settle in rural areas. The use of grants from the various funds or subsidies by the local communities will in some cases be necessary, in addition to the setting up of proper diagnostic facilities, if the problem is to be solved. The surveys recommended in items 8 and 9 should include the needs of rural areas as to additional physicians, and investigation should be made of the most feasible method of alleviating the shortages.*

12. Postponement of consideration of revolutionary changes while 60,000 medical men are in the service voluntarily and while 12,000,000 men and women are in uniform to preserve the American democratic system of government.

This, of course, refers to legislation such as the Wagner-Murray-Dingell Bill. Lest there be misunderstanding, let me state at the start that this does not mean that the American Medical Association is weakening in its stand against national compulsory sickness insurance. It merely means that, with such a large proportion of doctors and the public in service and unable to give their opinions, no such revolutionary change should even come up for discussion until all the people have an opportunity to express themselves.

We are unalterably opposed to the Wagner-Murray-Dingell Bill for the following reasons: It is un-American; it is inordinately expensive, involving an 8 per cent pay roll tax up to $3,600 of income, and this probably is inadequate. In fact, a recent economic survey indicates that with a national income of $120,000,000,000 a 15 to 17 per cent tax will be necessary and even this, perhaps, inadequate. It sets up another Federal bureaucracy with a lay board—the Social Security Board—at its head, to decide all medical matters, and although the administrative head is the Surgeon General, who incidentally usually is, but need not by law be, a physician, nevertheless he is an appointive, not an elective, official and he is subject to the dictates of the lay board; a third party, namely the government, is brought between the doctor and the patient, and the doctor is responsible to that third party. The head of the government camel is thrust into the tent of medical education and medical research. While free choice of physician is provided for in the bill, this is a "come on", as it means free choice of the physician who will take part in the scheme. A poor type of medical care is encouraged—quantity without regard to quality. Inefficiency, red tape and political medicine will result. Should the bill be enacted, government control would cover not only doctors but eventually dentists, nurses, technicians, hospitals, medical and hospital supplies and equipment. Notwithstanding Senator Wagner's claim that this bill is not socialized medicine, it is just that. It is paternalistic and inevitably will lead to national socialism.

The *Saturday Evening Post* has the following to say: "One reason why the compulsory state seems to be gaining on us is defeatism among the vast majority who don't want any part of it. We have been told so often and so emphatically that collectivism is 'inevitable' that we have

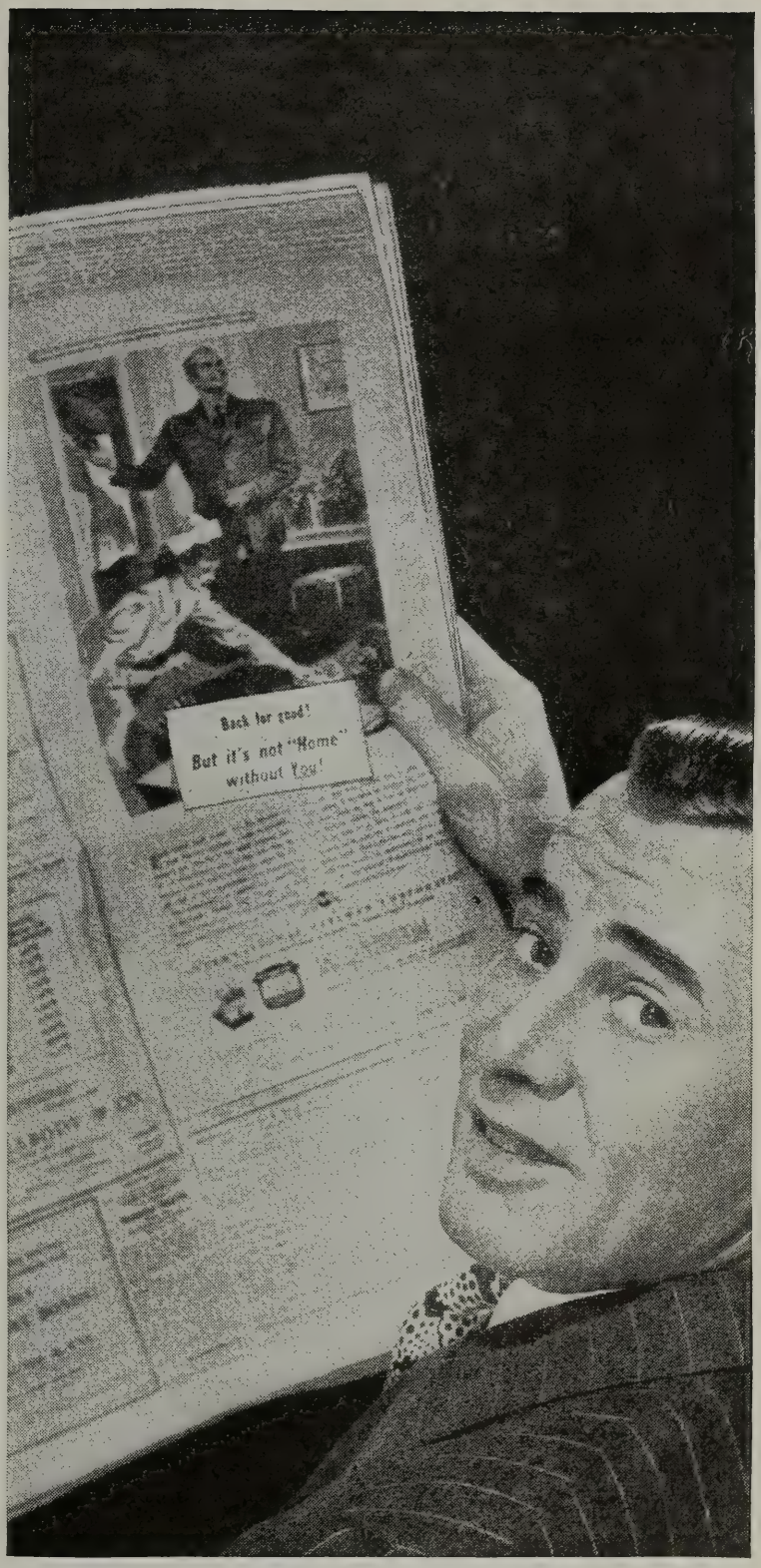
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come to believe it, as if some strange bacterial growth were gnawing at our economic vitals and it was too late for an operation. Investigation of specific symptoms usually reveals that the only 'inevitable' feature of the march toward collectivism is the determination of the little group which wants to collectivise us."

The wording of this item is already somewhat obsolete, as there are no longer 60,000 physicians or 12,000,000 persons in the services. The number is dropping steadily. The purpose of this item originally, however, was to protect the rights of all Americans to express themselves on any revolutionary change affecting their daily lives.

It is recommended that the American Medical Association give notice that it has not only in the past, does now, but will in the future oppose any legislation which by its very nature engenders a poor type of medical care, encourages dependency or regiments either the patient or the physician.

We consider such legislation as compulsory sickness insurance, no matter how it may be dressed up, as reactionary. There have been attempts for over thirty years to bring about compulsory sickness insurance in some parts of this country and for several years nationally. All the bills introduced have the same basic faults. It is the same old specter with the addition of occasional new cosmetics in the hope that they will fool the public into thinking it is something new. It is an all or nothing program and is in the nature of a "shotgun prescription".

On the other hand, our program attacks the basic deficiencies, offers specific treatment for specific ills is elastic and can be modified from time to time as conditions indicate.

CONCLUSION

It would be better to rearrange the order of the program so that it may be divided into four general aims.

I. Those primarily educational. This covers items 1 and 8, namely the removal of economic barriers so that a great deal of medical care will be unnecessary by eliminating its need; and extension of information to the people on services available.

In our educational program we particularly urge that state associations do their utmost to reactivate and revivify the county societies. The vast majority of these are poorly attended and the members are indifferent to the problems that beset us. No education of the public can be successful unless the profession also is fully educated.

II. Those primarily calling for positive legislation or administrative action by governmental agencies. This includes items 2, 6, 7, 9, 10, 11, 13 and 14; namely, extension of public health service for the prevention of disease; surveys to determine our needs, with these surveys continuous so that our remedies may keep pace with our necessities; the setting up of proper diagnostic facilities where lacking; Federal aid where local communities can not finance their necessary activities, but the activities to remain under local control; the readjustments in personnel requirements of the services; the necessary relocation of physicians, and necessary changes in the draft regulations.

III. Those calling for positive action but not as a rule legislative action. This includes items 3, 4 and 5; namely, extension of hospital and medical insurance on a voluntary basis, already of proved value, to cover the country; and the use of this principle in caring for the indigent.

IV. The one item calling for negative action, namely item 12. This refers to the Wagner-Murray-Dingell Bill and other types of vicious legislation.

Finally, just as we have in our program recommended surveys of our medical facilities so that they may be kept up to the best possible level, so the Board of Trustees and the Council on Medical Service and Public Relations should continuously survey the constructive program for medical care and likewise keep it constantly up to date so that it will stay at least even with and, if possible, a step ahead of the needs of the public.

College of Physicians' Meeting

The American College of Physicians will resume its annual meetings in 1946 with a session in Philadelphia, May 13-17, with headquarters at the Municipal Auditorium. The meeting will be conducted under the presidency of Dr. Ernest E. Irons, Chicago, and the general chairmanship of Dr. George M. Piersol, Philadelphia. Additional details may be obtained by addressing E. R. Loveland, the executive secretary, 4200 Pine St., Philadelphia 4.

Col. Howard A. Rusk, M. C., A. U. S., who was chief of the Convalescent Division, Office of the Air Surgeon, has been appointed Consultant on Physical Rehabilitation for the Baruch Committee on Physical Medicine.

The American Life Convention and the Life Insurance Association of America are sponsoring a medical research program by 143 life insurance companies with funds of $3,500,000 in prospect for the next six years. Initial research will be in the field of heart and arterial diseases, which have been termed "Number 1 Killer". In addition to aiding institutions engaged in studying the cause and cure of heart ailments, the insurance group will establish medical-research fellowships for individuals.

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FORMULAC, newly introduced on the market, is the trade name for a fortified infant food which makes supplementary vitamin administration unnecessary.

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NEW YORK, N.Y.

Suggestions for Control of Ringworm of the Scalp Are Issued by State Director of Health Heering

MICROSPORON audouini is the principle cause of the present epidemic of ringworm of the scalp among school children, microsporon lanosum causing only an occasional case. The fungus is spread from child to child through direct and indirect contact. A very important source of spread is contaminated barbers' instruments. Since the disease is subject to spontaneous cure shortly after puberty, the concern is with the preadolescent.

Editor's Note: Because of the apparent increasing prevalence of ringworm of the scalp among school children, Dr. Roger E. Heering, Ohio director of health, at the request of The Journal, has prepared the accompanying article in which suggestions for the control of this disease are outlined. Physicians in private practice can be of major assistance to health and school officials in efforts to control this disease through prompt diagnosis and treatment and adequate warning to parents on control methods.

RECOMMENDATIONS FOR CONTROL

1. Examination of every school child with the Wood Light, by a physician or properly trained nurse or technician. Siblings of preschool age of infected children should also be examined. Complete records should be kept of all positive cases. Negative children should be re-examined every two weeks. Positive cases should be referred to their family physicians or to a treatment center.

2. If the epidemic is of serious proportions, all children should wear caps in school and other public places. No child should be allowed in moving picture houses, playgrounds, swimming pools and the like, who does not have a registration card indicating examination and permission to be in such a public place.

3. Barber shops should be inspected to insure that proper precautions are being taken to prevent spread of infection.

4. An educational campaign should be conducted for the benefit of parents to acquaint them with the nature of the disease, its mode of spread, and precautions to be taken for their children.

5. In the event the epidemic assumes such proportions as to defy control through referral of cases to private physicians, the establishment of treatment centers in the schools may be advisable.

RECOMMENDATIONS FOR TREATMENT

1. Examination of each child with Wood Light and microscopic examination and/or culture if necessary.

2. X-Ray epilation or close clipping of hair.

3. Daily application of medicament by nurse or technician under medical direction.

4. If hair is clipped, this should be repeated every ten days preceded by a shampoo at home.

5. Wood Light examination after each clipping. If the Wood Light examination is negative but scales and broken hairs are present, a direct examination and culture should be made for fungi.

6. The child may be regarded as cured when there are no longer florescent hairs in the scalp and when cultures are negative. It has been found that infected hair floresces for about two weeks after the fungus is dead, so it is safe to discharge a patient when there is no florescence under the Wood Light.

7. After investigating some seventeen of the commonly used fungicidal preparations for topical application, the U. S. Public Health Service recommends 5 per cent salicylanilide in Carbowax No. 1500 or 5 per cent copper undecylenate in Carbowax No. 1500.

BARBER SHOPS

Barbers will maintain that they can recognize all cases of ringworm of the scalp and will not cut the hair of infected children; that they keep all instruments properly sterilized, all of which is not true. The disinfectants used commonly in barber shops, such as formaldehyde, mercuric iodide, Roccal, Zephiran, etc., are all insufficient fungicidal agents, except, perhaps, if used in greater concentrations than is the practice and for longer periods of exposure.

Children under 16 years of age should not be clipped with electric clippers since these are difficult to sterilize. Hand-clippers or scissors should be used.

Hand-clippers and other instruments can be sterilized by immersion in 10 per cent Lysol for 15 minutes or immersion in boiling water containing 1 per cent Lysol for 2 minutes.

Plastic combs and brushes will not tolerate immersion in Lysol or similar solutions. Metal or bakelite combs and brushes, if the latter have natural bristles, will stand proper sterilization.

Electric clippers may be safely sterilized by immersion in a mineral oil of medium viscosity, such as liquid petrolatum, having a boiling point of 150° - 250° C. The oil should be kept at a

temperature of 90° to 100° C. The clippers should be wiped free of hair, immersed in the hot oil for at least two minutes being sure that the blades and lower part of the clipper are well covered. Excess oil is wiped off after sterilization and the instrument is ready for use.

Barbers' hair-cutting cloths should be sterilized by boiling.

Letter To the Editor From Dr. M. A. Blankenhorn, Cincinnati

Editor,
Ohio State Medical Journal.

Dear Sir: If the business policies of The Ohio State Medical Journal are in harmony with the social practices of the members, the advertising manager should receive some instruction in the matter of displaying race prejudice, i.e., Jim Crow ethics.

I refer to an advertisement published in the November issue paid for by the Southern Medical Association which in substance excluded colored members of the medical profession from the Association's Cincinnati meeting.

Your manager has defended his position by saying that he has nothing to do with the policies of the Southern Medical Association and therefore he can not be charged with a display of prejudice in accepting an advertisement.

I disagree with his view as concerns our journal. I read the journal and found a display of race prejudice, printed by my journal at a profit. I don't like it.

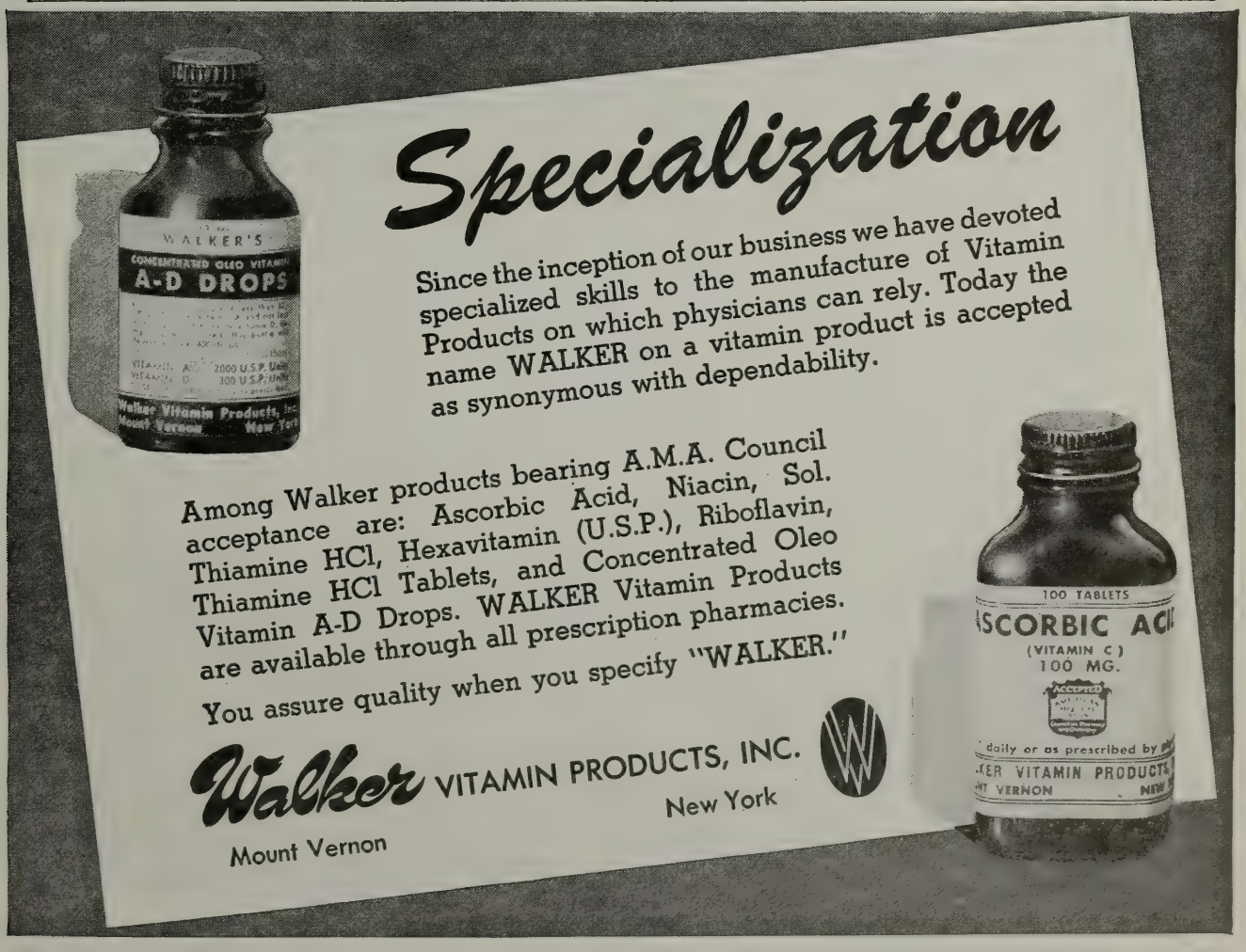
I am sending you this letter to publish or not, as you see fit, for I wish in some way to disavow such prejudice and apologize for the journal to the many members of the white race who feel as I do about it.

It may interest you to know that the president of the Cincinnati Academy of Medicine refused a similar advertisement proffered for its local journal.

Sincerely yours,
M. A. Blankenhorn, M.D.,
Director,
Department of Internal Medicine,
University of Cincinnati.

Dr. Hart E. Van Riper, Madison, Wis., pediatrician, has been named assistant medical director of the National Foundation for Infantile Paralysis. Dr. Van Riper was a resident in pediatrics at Children's Hospital, Cincinnati, in 1932.

Dr. Jonathan Forman, Columbus, has been reelected to represent the professions on the Board of Directors of the Ohio Chamber of Commerce.



In Memoriam

Alfonza A. Aratus, M. D., Cincinnati; Louisville Medical College, 1904; aged 75, died Dec. 1. A native of Naples, Italy, Dr. Aratus came to the United States when a boy. He practiced in Cincinnati for over 40 years. Dr. Aratus was a member of the Moose Lodge. His widow survives.

Melvin Leighton Battles, M.D., Norwalk; Pulte Medical College, Cleveland, 1904; aged 66; member of the Ohio State Medical Association, the American Medical Association and the American Institute of Homeopathy; died Nov. 27. Dr. Battles practiced in Franklin, Pa., from 1904 to 1910, during which time he served a term as coroner of Venango County. In 1910, he located in Greenwich and later in Olena, Huron County, Ohio, and in 1915 moved to Norwalk where he practiced for 30 years until ill health forced his retirement early in 1945. Dr. Battles served as a first lieutenant in the Medical Corps of World War I, received a commission as captain in 1927, and in 1929 was promoted to the rank of major, U. S. Medical and Staff Officers Corps, attached to the 112th Engineers at Cleveland, acting as regimental surgeon. He held a dual commission, as major in the Reserve Corps and in the Ohio National Guard. Dr. Battles was a member of the Methodist Church, had served as chairman of the National Bureau of Public Health, Past Exalted Ruler of the Elks, Past Commander of the American Legion, and was affiliated with the Masonic Order, Sojourners, Eagles, Association of Military Surgeons, Kiwanis, and the 40 and 8 Society. His widow and four children survive. A son, Dr. Edwin Deland Battles, practices in Waterville, N. Y.

William N. Boerstler, M. D., Stow; Western Reserve University School of Medicine, 1883; aged 89; died Nov. 30. Dr. Boerstler retired about five years ago, after having practiced medicine for over 50 years. He practiced in Peninsula for 16 years, and then located in Cleveland. Surviving are two daughters, a son and a brother.

Gilbert Thompson Brown, M. D., Dayton; Starling Medical College, Columbus, 1895; aged 76; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Physicians; died Nov. 17. A practicing physician for nearly 50 years, Dr. Brown first opened an office in Phillipsburg and later moved to Dayton. His hobby was oil paintings, and he recently received honorable mention at the 47th annual exhibit of the Art Institute at Richmond, Ind. His widow and two sisters survive.

Robert Hiram Butler, M. D., Bellefontaine; Miami Medical College, Cincinnati, 1906; aged 64; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Surgeons; member of the American Academy of Opthalmology and Oto-Laryngology; diplomate of the American Board of Oto-Laryngology; died Nov. 21. Dr. Butler practiced in Bellefontaine for 37 years. He was a former president of the Logan County Medical Society and had been prominent in community affairs. During World War I, Dr. Butler was a commander on the U. S. S. Mercy, a naval hospital ship. He was president of the Board of Trustees of the Bellefontaine Library; treasurer of the Amateur Trapshooting Association, Vandalia; and a member of the Board of Trustees of the local Presbyterian Church. Dr. Butler was a Mason. Surviving are his widow and four brothers.

Alfred Peters Cole, M.D., Ironton; Columbia University College of Physicians and Surgeons, 1891; aged 78; died Oct. 29. Retired for several years, Dr. Cole formerly practiced in Cincinnati. His widow and a sister survive.

Adolphus Hamilton Creps, M.D., Lima; Medical College of Ohio, Cincinnati, 1890; aged 78; died Nov. 28. A retired physician, Dr. Creps formerly practiced in Westminster and later in Lima for 25 years.

Percival Wm. Mark Curry, M.D., Cleveland; University of Toronto Faculty of Medicine, 1916; aged 55; died Nov. 20. During World War I, Dr. Curry was stationed in India as a captain in the Royal Army Medical Corps. Dr. Curry had practiced in Cleveland since 1925. He was staff physician at the Hawthornden State Hospital until his retirement because of illness last July. Surviving are his widow, his mother and three sisters.

Ralph Deming, M.D., Toledo; Hahnemann Medical College and Hospital, Philadelphia, 1902; aged 67; member of the Ohio State Medical Association and the Radiological Society of North America; Fellow of the American Medical Association; died Dec. 4. Dr. Deming was roentgenologist for Mercy, Robinwood and Maumee Valley hospitals at Toledo, where he practiced for nearly 40 years. During World War I he was a captain in the Army Medical Corps. Dr. Deming was a member of the Masonic Order and the Elks Lodge. His widow, two daughters, two sisters and two brothers survive.

Libeus Marshall Denman, M.D., Cincinnati; Cincinnati College of Medicine and Surgery, 1876; aged 94; former member of the Ohio State Med-

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ical Association and the American Medical Association; died Nov. 30. Dr. Denman retired two years ago after having been an active general practitioner in Greater Cincinnati for 67 years. Prior to beginning his medical training, he appeared headed for a newspaper career. As a young man he was a reporter on the *Tennessee Republican* and in 1871 and 1872 edited and published the *Waverly, Tenn., Journal.* Thirty-five years of his daily medical calls were via horse and buggy, up and down the Ohio River. Dr. Denman was local milk inspector in 1884, and was credited with leading a successful campaign to eliminate the so-called "slop-feed dairies" from the Millcreek bottoms section of Cincinnati. He was a member of the Masonic Order. His hobby was traveling in North America and Europe. Surviving are his brother, Dr. D. M. Denman, Cincinnati, and a son.

Herman Leo Harris, M.D., Columbus; Ohio Medical University, Columbus, 1897; aged 78; member of the Ohio State Medical Association and the American Medical Association; died Dec. 15. Dr. Harris practiced in Columbus for 47 years. He was a member of the staff of Mercy Hospital. Dr. Harris was a member of the Masonic Order, the Woodmen of the World and the Red Men. His widow and a daughter survive.

Harmon Howard Hays, M.D., Cleves; Medical College of Ohio, Cincinnati, 1879; aged 89; died Dec. 5. Dr. Hays practiced in his native Boone County, Ky., until 30 years ago. There he was known as a trainer of race horses as well as a physician. He then located in Cleves and continued in active practice until his retirement about ten years ago. Surviving are his widow and two sons.

James Sylvester Hedrick, M.D., Ada; Starling Medical College, Columbus, 1882; aged 86; former member of the Ohio State Medical Association and the American Medical Association; died Nov. 6. Dr. Hedrick practiced in Dunkirk for 55 years prior to his retirement about two years ago. He was a former delegate and legislative committeeman of the Hardin County Medical Society. Dr. Hedrick was a member of the Presbyterian Church and formerly belonged to the Elks, Odd Fellows and K. of P. Lodges. His widow, a daughter and two sons survive.

Carl Raimund Hiller, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1899; aged 69; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Surgeons; diplomate of the American Board of Surgery; died Dec. 3. Dr. Hiller practiced in Cincinnati for 45 years. He was a professor-emeritus of clinical surgery at the University of Cincinnati College of Medicine. An accomplished cellist, Dr. Hiller was a member of the Board of Trustees of the University of

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Cincinnati College of Music and had served that institution as president of the Board from 1935 to 1941. Dr. Hiller travelled extensively and studied abroad. He was a member of the French Legion of Honor and a Fellow of the Royal College of Microscopists of London.

Warren LaRue Hogue, M.D., Montpelier; Michigan College of Medicine and Surgery, Detroit, 1890; aged 82; former member of the Ohio State Medical Association and the American Medical Association; died Nov. 17. Dr. Hogue practiced in Williams County for over 50 years. He was a former president of the Williams County Medical Society. Surviving are a daughter and two sons.

Clarence Ludlam Hyde, M.D., Akron; University of Michigan Homeopathic Medical School, Ann Arbor, 1906; aged 67; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Physicians; died Dec. 1. Long active in the fight to combat tuberculosis, Dr. Hyde was superintendent of the Edwin Shaw Sanatorium for 25 years, and had just gone through a strenuous campaign to put across a tax levy for the support of that institution. He was a former president of the Summit County Medical Society and chief of staff of the Akron City Hospital. Dr. Hyde was a Mason. His widow, a daughter and a son survive.

Howard E. Jones, M.D., Circleville; Medical College of Ohio, Cincinnati, 1876; aged 92; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Dec. 12. One of the oldest general practitioners in the United States, Dr. Jones was in active practice for 69 years. He was a former president, vice-president and delegate of the Pickaway County Medical Society. Dr. and Mrs. Jones were co-founders of the Ohio History Day Association which sponsors the annual Logan Elm celebration. He was author of "Nests and Eggs of Birds of Ohio", and many other books and special articles. Dr. Jones taught physiology at Columbus Medical College for six years and later lectured on physiology at Kenyon College. Surviving are his widow, two daughters and two sons, one of whom is Dr. Lloyd Jonnes, Circleville.

Joseph J. Kotershall, M.D., Cleveland; University of Wooster, Medical Department, Cleveland, 1903; aged 64; member of the Ohio State Medical Association and Fellow of the American Medical Association; died Dec. 10. Dr. Kotershall practiced on Cleveland's West Side for over 40 years. In 1940 he was honored by 75 of his colleagues with a surprise dinner in recognition of his service to the profession and the community. He was a member of the Catholic Church. Surviving are his widow, three daughters and two brothers,

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including Dr. Edward Kotershall, with whom he had been associated in practice.

Frank E. McKim, M.D., Marietta; Medical College of Ohio, Cincinnati, 1884; aged 84; member of the Ohio State Medical Association and the American Medical Association; died Oct. 25. Dr. McKim practiced in Marietta for over 50 years. He was secretary of the Washington County Medical Society in 1919.

Daniel Ward Philo, M.D., Fremont; Physio-Medical College of Indiana, Indianapolis, 1901; Toledo Medical College, 1906; aged 72; former member of the Ohio State Medical Association and the American Medical Association; died Nov. 29. Dr. Philo went to Fremont 25 years ago from Woodville where he had previously practiced. He served in the Spanish-American War, and was a member of the Methodist Church, the Masonic Order and the American Legion. His widow and a brother survive.

Frank Siedenburg, M.D., Portsmouth; University of Illinois College of Medicine, Chicago, 1907; aged 65; member of the Ohio State Medical Association and the American Medical Association; died Nov. 1. Dr. Siedenburg had been assistant medical examiner for the Norfolk & Western Railway since 1942. For many years he was a member of the staff of Schirrman Hospital. Surviving are his widow and a daughter.

William Gale Stinchcomb, M.D., Bellefontaine; Bellevue Hospital Medical College, New York, 1895; aged 74; member of the Ohio State Medical Association and the American Medical Association; died Dec. 19. Dr. Stinchcomb retired in 1943 after having practiced in Bellefontaine for 48 years. Dr. Stinchcomb was an officer in the Army Medical Corps in 1918-1919. He was a member of the Board of Trustees of the Bellefontaine Public Library for 25 years acting as treasurer most of that time. Dr. Stinchcomb was a member of the Methodist Church and the American Legion. He is survived by his widow and his daughter.

Allen Alfred Yoder, M.D., Akron; Medico-Chirurgical College of Philadelphia, 1898; aged 75; died Nov. 13. Dr. Yoder practiced in Akron for 34 years. He was a Mason.

According to the *Statistical Bulletin* of the Metropolitan Life Insurance Company, battle death losses in our armed forces during World War II will total close to 325,000, more than six times as high as that in World War I. About four-fifths of our total combat losses in the war just ended, or between 255,000 and 260,000, were suffered by the Army; the remaining 65,000 to 70,000 were incurred by the Navy, including the Marine Corps and Coast Guard. Of the Navy's total, about 23,000 were Marines, and about 900 Coast Guard men.

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ACTIVITIES OF COUNTY SOCIETIES

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

CLERMONT

Dr. L. Howard Schriver, Cincinnati, President of the Ohio State Medical Association, was guest speaker at a meeting of the Clermont County Medical Society, Nov. 21, at the home of Dr. F. S. Skeen, Batavia. Dr. Schriver discussed some of the current problems faced by the medical profession and explained Ohio Medical Indemnity, Inc.

Following are the officers of the society for 1946: Dr. Pearl Zeek-Minning, Williamsburg, pres.; Dr. O. C. Davison, Bethel, vice-pres.; Dr. J. M. Coleman, Loveland, secy.-treas.; Dr. Minning, delegate; Dr. Coleman, alternate.

CLINTON

Dr. Carl A. Wilzbach, health commissioner of Cincinnati, spoke on "Major Public Health Problems", at a joint meeting of the Clinton County Medical Society and the Clinton County Nurses' Association, Nov. 7, at the General Denver Hotel, Wilmington.

Medical matters of present importance were discussed at a meeting of the society Dec. 4. Reports were made by members who attended the State Conference of County Society Presidents and Secretaries held at Columbus Nov. 11, and the Southern Medical Association meeting at Cincinnati, Nov. 11-15.—R. W. DeCrow, M.D., secretary.

Officers of the society for 1946 are: Dr. Robert Conard, Wilmington, president; Dr. L. H. Fullerton, New Vienna, vice-pres.; Dr. R. W. DeCrow, Wilmington, secy.-treas.; Dr. Conard, delegate; Dr. J. H. Frame, Wilmington, alternate.

HAMILTON

The Academy of Medicine of Cincinnati presented the following programs during December:

CLASSIFIED ADVERTISEMENTS

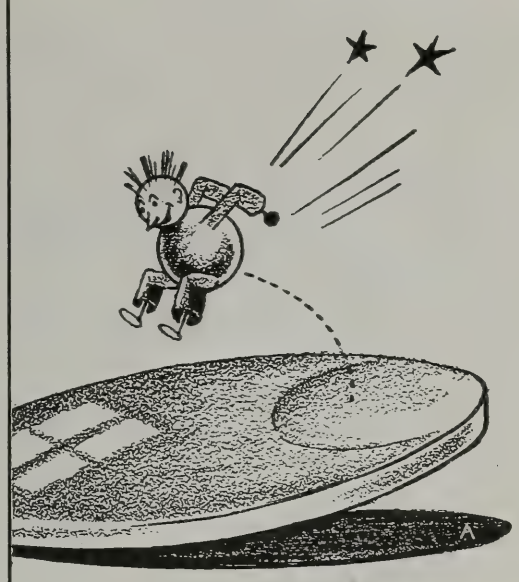
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ZANESVILLE

Dec. 4—"Experimental Approach to the Understanding of Neurotic Symptoms", Dr. Jules H. Masserman, assistant professor of psychiatry, University of Chicago Clinics and Research associate, Otto S. Sprague, Institute, University of Chicago.

Dec. 18—"Experiences of the Medical Consultant in the Fifth Service Command, with Special Reference to Cardio-Vascular Disease", Col. Johnston McGuire, M.C., A.U.S.

New officers of the Academy are: Dr. David A. Tucker, Jr., president; Dr. Charles E. Hauser, pres.-elect; Dr. David W. Heusinkveld, secy.; Dr. Dale P. Osborn, treas.; Drs. E. A. Kindel, Lloyd B. Johnston, H. H. Shook, E. O. Swartz, Harold F. Downing, Donald J. Lyle, William J. Graf, Edward J. King, Emil R. Swepston, delegates; Drs. C. Ross Deeds, Harry L. Fry, Edward J. McGrath, Richard S. Tyler, Louis J. Hendricks, A. R. Vonderahe, Joseph G. Crotty, A. Clyde Ross, Vinton E. Siler, alternates.—R. A. Swink, executive secretary.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

CLARK

The following Springfield physicians are officers of the Clark County Medical Society for 1946: Dr. S. C. Yinger, pres.; Dr. F. A. Halloran, vice-pres.; Dr. H. H. Ingling, secy.; Dr. G. M. Lane, treas.

DARKE

Officers of the Darke County Medical Society for 1946 are: Dr. J. P. Gibbel, Hollansburg, pres.; Dr. R. M. Zeller, Greenville, vice-pres.; Dr. W. D. Bishop, Greenville, secy.-treas.; Dr. J. E. Gillette, Versailles, delegate; Dr. P. G. Lenhert, Arcanum, alternate.

MIAMI

A sound movie in color, "Non-Operative Treatment of Para Nasal Sinusitis", was shown at a meeting of the Miami County Medical Society, Dec. 7, at Stouder Hospital, Troy. The society voted to activate a committee of three discharged medical officers to give special attention to the medical care of returned veterans. Other business included the appointment of an advisory committee to reorganize the Woman's Auxiliary of the society. Three members recently returned from the service recounted some of their experiences overseas. They were: Dr. E. R. Ervin, Bradford, from the E.T.O.; Dr. Fred Hapke, Troy, of the C.B.I. Area; and Dr. Albert N. Farmer, Fletcher, who had both legs fractured while in Germany He is now a patient at the Vaughn General Hospital, Hines, Ill.

The society elected the following officers for 1946: Dr. Russell Gardner, Troy, pres.; Dr. E.

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MONTGOMERY

Approximately 200 members heard three colleagues relate their war experiences at a dinner meeting of the Montgomery County Medical Society, Dec. 5, at Miami Valley Hospital, Dayton. Dr. Roy D. Arn spoke on "Front Line Surgery". Dr. Harry R. Huston discussed "Organization and Problems of the Navy Medical Corps". Dr. N. J. Birkbeck showed and explained slides of the effect of the atomic bomb on Nagasaki.

Officers of the society for 1946 are: Dr. N. E. Leyda, pres.; Dr. G. C. Grout, vice-pres.; Dr. A. D. Cook, pres.-elect; Dr. R. E. Boswell, secy.; Dr. R. D. Hostetter, treas.; Drs. R. S. Binkley, M. R. Haley, M. D. Prugh and R. D. Dooley, delegates; Drs. R. K. Bartholomew, L. E. Baker and N. Shepard, alternates.—Marie T. Yoder, executive secretary.

Third District

(COUNCILOR: GUY E. NOBLE, M.D., ST. MARYS)

LOGAN

Officers of the Logan County Medical Society for 1946 are: Dr. Byron B. Blank, DeGraff, pres.; Dr. Clyde K. Startzman, Bellefontaine, vice-pres.; Dr. Frederick W. Kaylor, secy.-treas.; Dr. Charles L. Barrett, Bellefontaine, delegate; Dr. F. Blair Webster, Bellefontaine, alternate.

MERCER

The following are the officers of the Mercer County Medical Society for 1946: Dr. R. G. Slusher, St. Henry, pres.; Dr. M. L. Downing, Rockford, vice-pres.; Dr. A. J. Rawers, Celina, secy.-treas.; Dr. Rudolph G. Schmidt, Celina, delegate; Dr. E. J. Willke, Maria Stein, alternate.

Fourth District

(COUNCILOR: A. A. BRINDLEY, M.D., TOLEDO)

LUCAS

The Academy of Medicine of Toledo and Lucas County presented the following programs during December:

Dec. 7—General Meeting. "Experience in an Army General Hospital", Dr. Walter G. Maddock, associate professor of surgery, University of Michigan Medical School, Ann Arbor, and formerly commanding officer of the 298th General Hospital.

Dec. 14—Section of Pathology, Experimental

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Medicine and Bacteriology. "Clinical Pathological Conference on Blood Dyscrasias", Drs. Bernhard Steinberg, M. E. Goodrich, Foster Myers, John L. Stifel.

Dec. 21—Medical Section. Address by Dr. Frank Witker, chief of the department of obstetrics and gynecology, University of Tennessee Medical School, Memphis.—Bulletin.

PAULDING

Officers of the Paulding County Medical Society for 1946 are: Dr. Ray Mouser, Paulding, pres.; Dr. D. E. Farling, Payne, secy-treas.

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

ASHTABULA

The following Ashtabula physicians are officers of the Ashtabula County Medical Society for 1946: Dr. A. M. Mills, pres.; Dr. H. A. Tagett, vice-pres.; Dr. Wm. H. Eberle, secy.-treas.; Dr. R. B. Wynkoop, delegate; Dr. P. J. Collander, alternate.

CUYAHOGA

The following program was presented at a combined meeting of the Experimental Medicine Section of the Cleveland Academy of Medicine and the Cleveland Section of the Society for Experimental Biology and Medicine, Dec. 14: "Alterations in the Concentration of the Blood During Pregnancy", J. W. Mull, Ph.D., and Dr. A. H. Bill; "Testicular Deficiency Without Pituitary Failure in Fat Boys", Dr. E. Perry McCullagh; "Studies on Methods for the Assay of Adrenal Cortical Material in Urine", Dr. R. A. Shipley, R. I. Dorfman, Ph.D., E. Ross, M.S., S. Schiller, M.S., B. N. Horwitt, Ph.D.; "The Effect of Infection and Trauma in the Excretion of Urinary Cortion", Dr. Shipley, R. I. Dorfman, Ph.D., E. Buchwald, B.S., and E. Ross, M.S.; "Recent Experimental Studies of Endocrines in Insects", Berta Scharrer, Ph.D.—Bulletin.

Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

PORTAGE

At a meeting of the Portage County Medical Society, Dec. 6, at Robinson Memorial Hospital, Ravenna, Dr. Joseph C. Fiala, the retiring president, gave an address on "Carcinoma of the Prostate".—Emily Widdecombe, M.D., secretary.

SUMMIT

Dr. Charles L. Hartsock, department of internal medicine, Cleveland Clinic, spoke on "The Fatigue States", at a meeting of the Summit County Medical Society, Dec. 4, at City Hospital, Akron.—Bulletin.

New officers of the society are: Dr. Richard A. Gregg, president; Dr. Paul A. Davis, pres.-elect; Dr. Robert M. Lemmon, secy.; Dr. Wil-

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Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

BELMONT

Officers of the Belmont County Medical Society for 1946 are: Dr. J. B. Martin, St. Clairsville, pres.; Dr. Edward F. Arbaugh, Jr., Martins Ferry, pres.-elect; Dr. C. W. Kirkland, Bellaire, secy.-treas; Dr. Martin, delegate; Dr. Arbaugh, alternate.

Eighth District

(COUNCILOR: GEORGE F. SWAN, M.D., CAMBRIDGE)

GUERNSEY

The Guernsey County Medical Society has elected the following officers for 1946: Dr. O. R. Jones, Cambridge, pres.; Dr. E. E. Conaway, Cambridge, pres.-elect; Dr. M. S. Lawrence, Quaker City, secy.-treas; Dr. M. J. Thomas, Cambridge, delegate; Dr. J. A. L. Toland, Cambridge, alternate.

MUSKINGUM

Dr. R. E. S. Young, Columbus, a member of the Executive Committee of the Association of American Physicians and Surgeons, was guest speaker at a meeting of the Muskingum County Academy of Medicine, Dec. 5, at the University Club, Zanesville.—Beatrice T. Hagen, M.D., secretary.

Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

SCIOTO

Officers of the Hempstead Academy of Medicine for 1946 are: Dr. George D. Blume, New Boston, pres.; Dr. Walter H. Sisson, Portsmouth, vice-pres.; Dr. Garnet E. Neff, Portsmouth, secy.-treas.; Dr. D. A. Berndt, Portsmouth, delegate; Dr. W. A. Quinn, Portsmouth, alternate.

VINTON

Officers of the Vinton County Medical Society for 1946 are: Dr. H. D. Chamberlain, McArthur, pres. and delegate; Dr. Harold Carter, McArthur, secy. and alternate.

Tenth District

(COUNCILOR: GEORGE T. HARDING, M.D., COLUMBUS)

FRANKLIN

The Columbus Academy of Medicine presented the following programs during December:

Dec. 3—"Review of Surgery", Dr. Edwin J. Stedem.

Dec. 17—Banquet honoring members returned from the service, and their wives. "Health Education by the Medical Profession", Dr. W. W.

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Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

ASHLAND

The following Ashland physicians are the officers of the Ashland County Medical Society for 1946: Dr. L. G. Sheets, pres.; Dr. Geo. M. Emery, vice-pres.; Dr. R. L. Shilling, secy.-treas.; Dr. Emery, delegate; Dr. H. M. Gunn, alternate.

LORAIN

Dr. John T. Fawcett, Elyria, spoke on "Convalescent Treatment in Army Hospitals", at a dinner meeting of the Lorain County Medical Society, Dec. 11, at the Castle-on-the-Lake, Lorain.

Officers of the society for 1946 are: Dr. Myron E. Kishman, Lorain, pres.; Dr. John R. Dickason, Vermilion, vice-pres.; Dr. L. H. Trufant, Oberlin, secy.-treas.; Dr. Chas. R. Meek, Lorain, and Dr. S. V. Burley, Lorain, delegates; Dr. Valloyd Adair, Lorain, and Dr. Geo. D. Nicholas, Elyria, alternates.

WOMAN'S AUXILIARY NEWS

(BY MRS. FRED W. BROSIUS, MIDDLETOWN)
Chairman, Publicity Committee

NATIONAL MEETING

On December 5 the Woman's Auxiliary to the American Medical Association held a meeting for Board members, State Presidents, and Committee Chairmen, at the Knickerbocker Hotel, Chicago, Ill. Mrs. Roswell S. Fidler, Columbus, President of the Woman's Auxiliary to the Ohio State Medical Association, attended special sessions for the State Presidents and Mrs. J. L. Stevens, Mansfield, was a representative on the National Board.

LUCAS

Mrs. Rebecca Nelson reviewed Alice Tisdale Hobart's "The Peacock Sheds His Tail", at a meeting of the Woman's Auxiliary to the Toledo Academy of Medicine, Nov. 16, at the Toledo Woman's Club. The Auxiliary collected 2,250 pounds of medical supplies for Polish War Relief.

MAHONING

Forty members enjoyed the Fall luncheon of the Woman's Auxiliary to the Mahoning County Medical Society, Nov. 19, at the Women's City Club, with Mrs. J. N. McCann, Mrs. Milton Kendall and Mrs. Robert B. Poling as hostesses. Mrs. Renwick Miller reviewed "So Well Remembered", by James Hilton.

SCIOTO

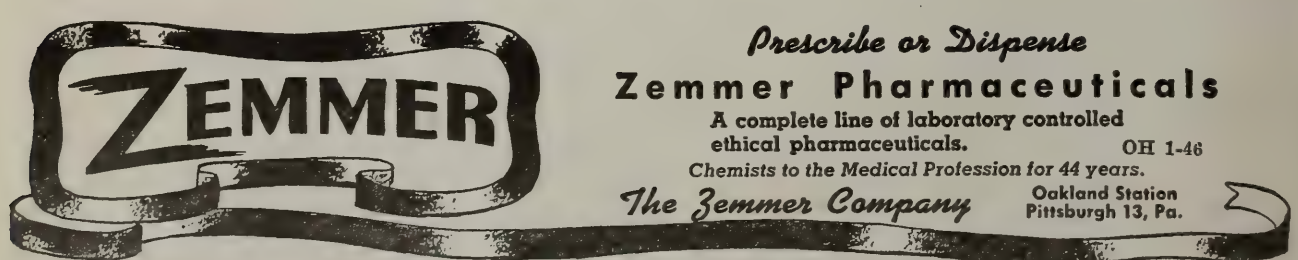
Mrs. William Singleton, president of the Woman's Auxiliary to the Hempstead Academy of Medicine, entertained 20 members at her home on November 14. A report of the state conference was given by Mrs. Singleton, stressing continuous efforts opposing the Wagner-Murray-Dingell Bill. Mrs. Clyde Fitch reported on the Canteen work for the war period. Over 5,000 service men were served by the auxiliary. A "bake sale" brought excellent results, sponsored recently by the members. Dr. C. L. Pitcher, guest speaker, related his experiences serving in India and showed a large and beautiful collection of pictures and souvenirs. Mrs. G. E. Neff and Mrs. Milton Levine assisted the hostess with refreshments.

SUMMIT

The Woman's Auxiliary to the Summit County Medical Society compiled a pamphlet enumerating some facts regarding the Wagner-Murray-Dingell Bill. It was considered so important that the Blue Cross Hospital Association ordered 5,000 copies. Many county auxiliaries are using this pamphlet through the courtesy of the Summit County Auxiliary. Mrs. C. F. Wharton, Akron, president of the Woman's Auxiliary to the Summit County Medical Society, will send you a copy of this pamphlet giving some facts on socialized medicine. County organizations may use this material by obtaining permission from the Summit County Auxiliary. It is very much worth while and should be obtained by all county auxiliaries.

TUSCARAWAS

Mrs. H. A. Coleman was hostess to the members of the Woman's Auxiliary to the Tuscarawas County Medical Society at her home on November 8. Plans were discussed for a public sale of miscellaneous articles, which will include fine glass and china. During the social hour the hostess served refreshments.





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CLINTON—Robert Conard, President, Wilmington; R. W. DeCrow, Secretary, Wilmington. 1st Tuesday, monthly.

HAMILTON—David A. Tucker, Jr., President, Cincinnati; David W. Heusinkveld, Secretary, Cincinnati. 1st and 3rd Tuesday.

HIGHLAND—J. C. Larkin, President, Hillsboro; W. B. Roads, Secretary, Hillsboro. 1st Wednesday, monthly.

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MIAMI—Russell Gardner, President, Troy; G. A. Woodhouse, Secretary, Pleasant Hill. 1st Friday, monthly, except July, August.

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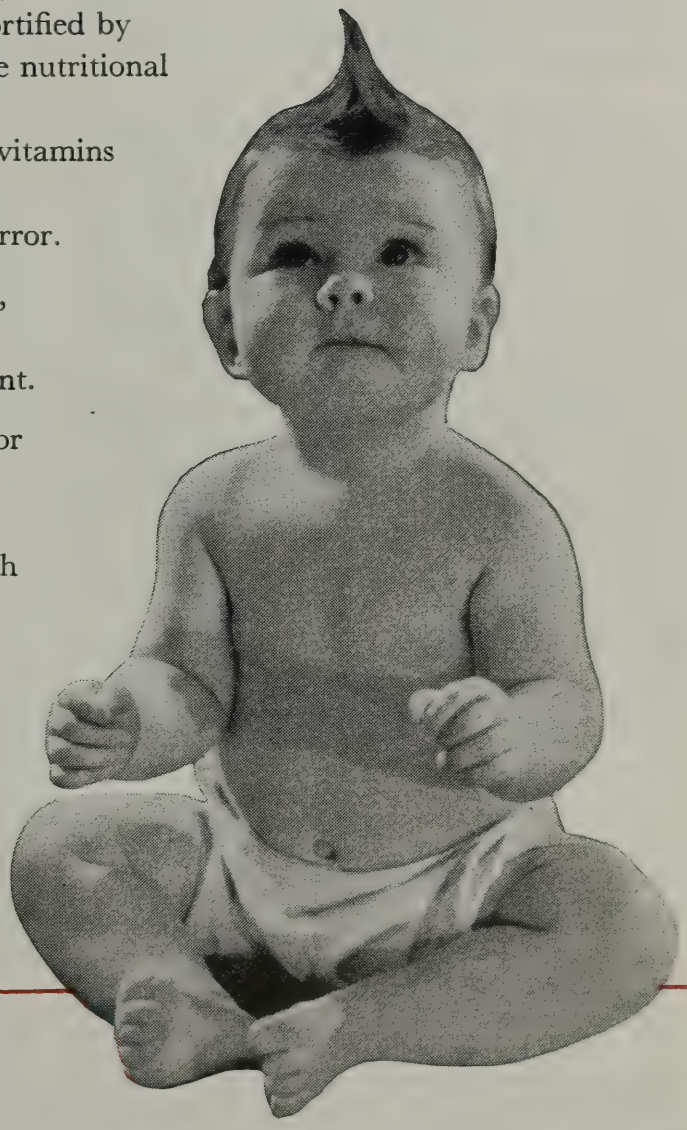
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The Physician's Bookshelf

New and Nonofficial Remedies, $1.50. *American Medical Association, 535 N. Dearborn St., Chicago*) contains description of the articles which stand accepted by the Council on Pharmacy and Chemistry of the Association on January 1, 1945. Should be on every physician's desk.

Take it Easy! The Art of Conquering Your Nerves, by Arthur Guy Mathews, ($2.98, *Sheridan House, New York City*) is a book for all because there are very few who have not experienced at some time or other the symptoms of a functional disturbance of our nerves. It offers relaxation as a help in preventing or overcoming a neurosis.

Industrial Hygiene, by L. B. Chenoweth, M. D., and William F. Machle, M. D., ($2.00. Revised Ed. *F. S. Crofts & Co., New York City*) is a handbook of hygiene and toxicology for engineers and plant managers by these outstanding authorities in the University of Cincinnati. It is a "must" book for all student engneers, and all physicians who deal with workers and their working conditions.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1944, with the comments that have appeared in the Journal. ($1.00. *American Medical Association, Chicago*).

Tecnicas de Laboratorio en el Tifus Exantematico por el Prof. Dr. G. Clanero del Caupo y el Dr. F. Perez Gallardo. Editado oficial mente por la direcion general de Sanidad, Madrid, Spain, is a well illustrated volume giving a discussion of all the necessary laboratory techniques in the study of typhus.

Measles, Pneumonia, and Encephalomyelitis, by Paul Gates Kreider, M. D., (*Route 2, Springfield, Ill.*) is a study of 36 fatal cases. An interesting and valuable treatise.

An Introduction to Medical Science, by William Boyd, M. D., ($3.50 3rd Ed. *Lee & Febiger, Philadelphia*) is designed to introduce the student nurse to the field of medical science. It has been a successful book and now is ready in this revised edition to do even greater service. Modern drugs, nutritional deficiences, organotherapy and physiotherapy have come into their own. The book is not only for a student nurse; it is an excellent book to put into the hands of an intelligent layman who is seeking knowledge.

Chemistry and Physiology of the Vitamins, by H. R. Rosenburg, Sc. D., ($7.50. A Berser Reprint 1945, *Interscience Publishers, Inc., New York City*) is essentially a reprint of the similar volume which appeared in 1942 and was given fullsome praise in this column. Only actual errors have been corrected. The "Recommended Daily Allowances" as published in January, 1943, by the Food and Nutrition Board of the National Research Council, however, has been added.

Francois Magendie, Pioneer in Experimental Physiology and Scientic Medicine in XIX Century France, by J. M. D. Olmsted, ($5.00. *Schuman's, New York City*) is a distinguished contribution to medical history. It was in these days that French Medicine gained a commanding influence in the western world. Soon after Magendie's death, it passed to Germany. It was his leadership, however, that established the experimental method of investigation and opened the way for the great achievements of modern medical science. This book deserves a place in every medical library and in the shelves of every scholarly physician.

Pathology of Tropical Diseases, by J. E. Ash, M. D., and Sophie Spits, M. D., ($8.00. *W. B. Saunders Co., Philadelphia*) is a remarkable book for its conciseness, lucidity, and authority, It supplies in text and picture the pathology which is missing from most books on tropical medicine.

What People Are, A Story of Normal Young Men, by Clark W. Heath and Associates, ($2.00. *Harvard University Press, Cambridge, Mass.*) reports the results of six years of cooperative research into the lives of a selected group of Harvard undergraduates. The approach is clinical and the book serves as an introduction to long-term research with prolonged follow-up with funds of Grant Foundation, Inc.

Textbook of Surgery, edited by Frederick Christopher, M. D., ($10.00. 4th Ed. 1483 illustrations, over 762 figures, *W. B. Saunders Co., Philadelphia*) with each of its chapters written by an outstanding authority and teacher, has become one of our best student texts.

Crime and the Human Mind by David Abrahamsen, M. D., ($3.00. *Columbia University Press, New York City*) deals, as you would expect, with the psychiatric aspects of crime. The author shows that crimes are largely the symptoms of personality difficulties. Anti-social behavior results from a combination of an individual's tendencies, and the situation of the moment, acting against his mental resistances. In all, more interesting than a detective story and most valuable to all who must at sometime attempt to understand the mind of a criminal.

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JONATHAN FORMAN, M.D., *Editor*

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Folic Acid (L. Casei Factor), an Essential Pan-Hematopoietic Factor: Experimental and Clinical Studies

CHARLES A. DOAN, M.D., HENRY E. WILSON, JR., M.D., and CLAUDE-STARR WRIGHT, M.D.

THE interest in "folic acid" (*Lactobacillus casei* factor) associated with experimental vitamin B deficiency studies in animals is being currently stimulated by a series of clinical reports from Spies and his associates[1,2] on the response of human macrocytic anemias to the recently synthesized *L. casei* factor.[3] Earlier studies have indicated that various preparations containing "folic acid" exert a profoundly stimulating effect on growth and hemopoiesis in rats,[4,5,6,7,8] chicks,[9] and guinea pigs.[10]

Interest in *Lactobacillus casei* factor was first aroused in this laboratory several years ago during the search for an active principle, which would prevent or correct the progressive panmarrow hypoplasia and peripheral hemocytopenia which occurs in Macaccus mulatta monkeys under certain nutritional deficiency conditions. Langston, et al., reported in 1938[11] that monkeys, which were maintained on a basic vitamin B deficient diet developed signs of nutritional deficiency, with anemia and leucopenia, which could be prevented or corrected by the daily administration of 2 grams of liver extract or 10 grams of dried brewer's yeast. The unidentified but essential component in these two dietary supplements was designed "vitamin M."

In 1940-1942 Langston's experiments were repeated in this laboratory using monkeys maintained on a vitamin B-free diet.[12,13] These investigations were then extended using calculated supplements of niacin amide, thiamin, riboflavin, calcium pantothenate, pyridoxin, inositol, para-aminobenzoic acid, choline, pimelic acid and glutamine, but without influencing favorably the progressive hemocytopenia or other signs of nutritional deficiency. A leucopenia invariably developed as the nutritional deficiency was continued, though significant anemia occurred in less than half of our monkeys. Both the clinical manifestations and the varying degrees of marrow depression with hemocytopenia could be prevented or corrected by the oral or parenteral administration of liver extract. It thus became clear that the essential element present in liver, and previously termed "vitamin M" by Langston,

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From the Department of Medicine, Ohio State University, Columbus, Ohio. Aided by grant from the Conly Research Fund, Ohio State University. Submitted January 2, 1946.

UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE Founded 1807

et al., was not included in or identical with any or all of these several separate constituents of the B-complex.[14]

At this time a "folic acid concentrate",[15] a substance prepared from yeast, containing, primarily, *L. casei factor*, became available* and was administered parenterally to three of our nutritionally deficient monkeys. All three animals showed marked clinical improvement and a return of all of the white cell elements to normal levels or above. In one of the two monkeys showing a significant anemia (Fig. I), "folic acid concentrate" administration was followed by a reticulocyte crisis, and optimum increase in red blood cells and hemoglobin, in addition to the dramatic increase in thrombocytes and granulocytes,—phenomena seen regularly following liver therapy in human pernicious anemia (Fig. III). Waisman and Elvehjem,[16] in nutritional studies in monkeys noted that the administration of folic acid concentrate alleviated the leucopenia of the deficient state. Our own supplies of "folic acid" were then interrupted by the war and further experimental and clinical studies became impossible. Day, et al.,[17] recently (1945) have reported clinical and cytologic remissions in "vitamin M" deficient monkeys using a "highly purified" preparation of *L. casei* factor from liver.

During the summer of 1943 one of us (CAD) joined with Spies and associates in Birmingham in initiating a study of the effect of folic acid on selected patients with nutritional deficiency showing predominantly a chronic leucopenia with recurrent mouth ulcers. This investigation was continued over a two-year period utilizing first *L. casei* factor obtained from liver extract residue, and, later, the synthetic product. The results were published in September, 1945.[18] Spies, et al., then administered the synthetic folic acid, both orally and parenterally, to patients with macrocytic anemia in relapse, and reported in November, 1945,[1] that there was "a significant hemopoietic response" and that "in every instance (five patients) the number of reticulocytes increased in the peripheral blood and the red cell counts and hemoglobin rose toward normal levels". Vilter, Spies, et al., then reported that 14 cases of macrocytic anemia, including pernicious anemia, pregnancy, and pellagra, have shown a response to folic acid. The tropical sprue occurring in Cuba is reported to be responding similarly.[2]

Moore and associates[19] have just published similar studies with the synthetic *L. casei* factor. Clinical and hematologic remissions were induced in two cases of Addisonian pernicious anemia, in one case of macrocytic anemia of pregnancy, and in one case of non-tropical sprue. Oral doses of 50 mgm., and parenteral doses of 20 mgm. daily, were reported as being uniformly effective to date. Darby and Jones[26] have also noted a similar response in two patients with sprue.

Knowing of these observations of Spies[20] and of Moore [21] and having access to the same source of synthetic material*[3], we have sought to confirm and to supplement their findings and their data by: (1) attempting to establish the minimal effective dose of synthetic folic acid in the individual patient; (2) following the cellular maturation in bone marrow and correlating these changes with the quality and quantity of circulating elements in the peripheral blood, as we have previously reported for liver extract;[22] and (3) determining the possibility of substitution of synthetic folic acid for liver extract in those patients developing a high degree of persistent intolerance and recurring hypersensitivity to liver.

CLINICAL STUDIES

I. Pernicious Anemia.

Mr. F.E.B., a 57 year old, white, railroad conductor, was referred to the Hematology Service of the University Hospital with the tentative diagnosis of pernicious anemia.** During the 11 months prior to this medical consultation he had noted an insidious increase in fatigability with dyspnea, palpitation and vertigo on even slight exertion, together with soreness of the tongue and some numbness in the hands, ankles, and feet. Despite a good appetite, there had been a decrease in weight from 215 to 190 pounds.

Past history was non-contributory. Review of systems was essentially negative except for mild constipation which was the only gastro-intestinal complaint.

The patient stated that his father died in 1929 at the age of 77 with "pernicious anemia which was not treated".

Physical examination revealed a well developed, alert, middle-aged man who tired very easily. There was a yellow pallor to the skin. Temperature, pulse and respiration were normal. Blood pressure was 100/60. Sclerae were icteric. A few scattered cervical lymph nodes were barely palpable. Fundiscopic examination was negative. Gingivae were edentulous. The tongue was pale, smooth, and glistening with moderate atrophy of the papillae. Other than a moderate emphysema the lungs were normal. There was no cardiac enlargement, heart sounds were faint but the quality was good. The liver border was palpated 4 cm. below the right costal margin on deep inspiration. Enlargement of the spleen was not demonstrable.

Neurological examination revealed markedly diminished vibratory sense over the bony prominances of the lower extremities and Rhomberg's sign was definitely positive. The deep reflexes, however, were physiological. Despite the subjective numbness there was no objective loss of superficial sensation.

The laboratory data are summarized in Fig. II. The initial total red cell count was 1,490,000 per cu. mm. with 5.8 grams of hemoglobin; the mean corpuscular volume was 120 cu. micra; the hematocrit 18 per cent; reticulocytes 3.0 per cent. The total white blood cells

*Courtesy of S.M.A. Corp.

*The synthetic folic acid used was received from the Lederle Laboratories through the courtesy of Tom D. Spies, M.D.

**Referred by Wayne Brehm, M.D.

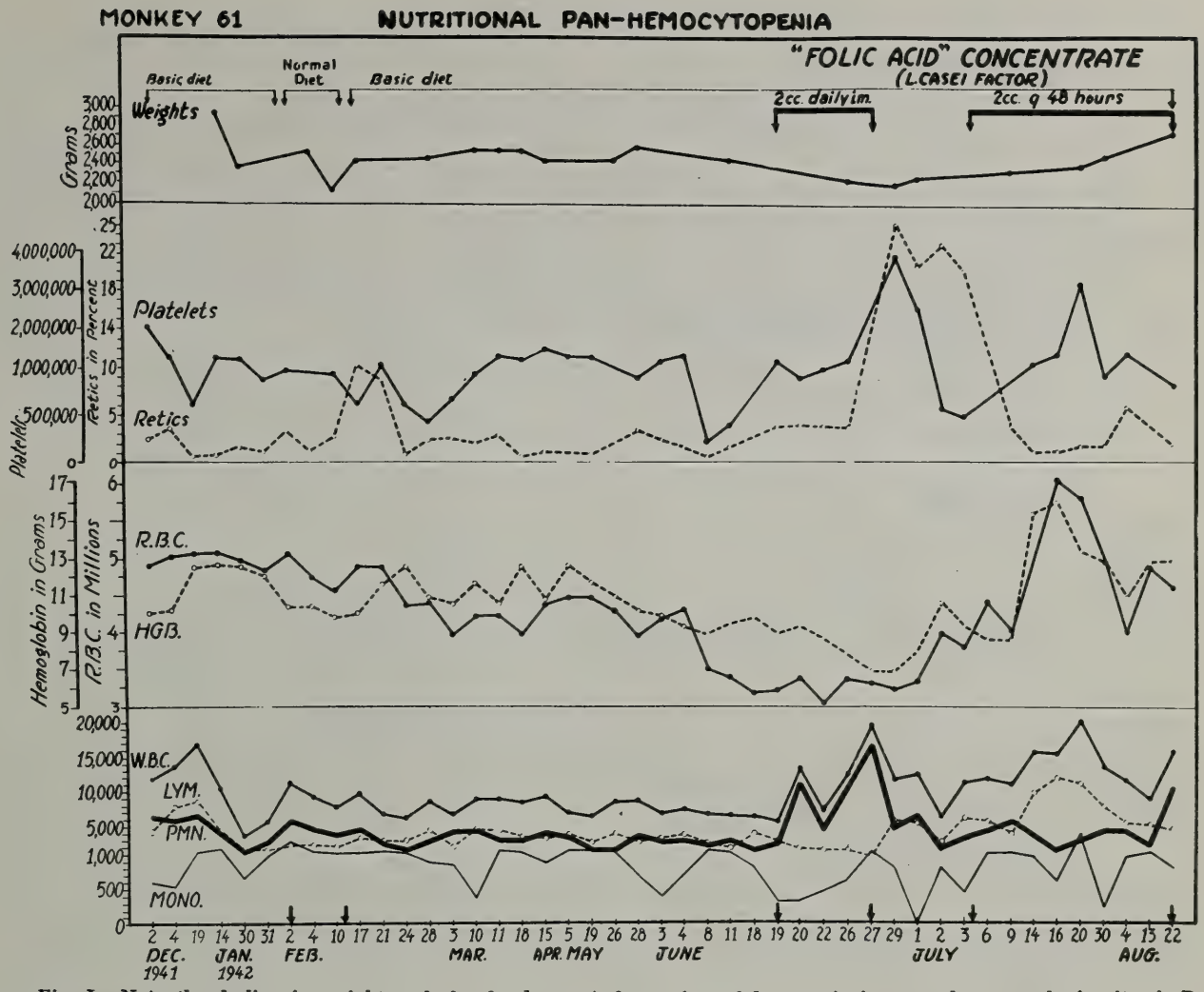


Fig. I. Note the decline in weight and the development of anemia and leucopenia in a monkey on a basic vitamin-B free diet, over a 6 month's period. Intramuscular injection of "folic acid concentrate" resulted in gain in weight, a reticulocyte crisis, and a return of all the blood cell elements to maximum normal levels.

were 5,000 per cu. mm. with the following supravital differential: PMN 34 per cent ("right shift"), small lymphocytes 46 per cent, intermediate 2 per cent, monocytes 7 per cent. The platelets were 366,540 per cu. mm. The corrected sedimentation rate was 0.2 mm. per minute (normal). There was a histamine refractory achlorhydria. The icterus index was 15; van den Berg direct positive; indirect 2.1 mgm. The basal metabolic rate was plus 15. Urinalysis was essentially negative. Roentgenological examination of the gastro-intestinal tract was normal.

Supravital examination of an aspirated specimen of hyperplastic sternal bone marrow showed a marked erythroid predominance with "left shift" to the immature megaloblastic stage, typical of erythrocyte maturation factor (EMF) deficiency.

The patient was admitted to the University Hospital for observation and treatment. He was placed on the usual meat-free, liver-assay diet (low in EMF), and followed by complete serial blood and bone marrow studies, (Fig. II); 2.0 mgm. of synthetic folic acid* were given intravenously for 20 consecutive days. The daily bone narrow examinations demonstrated a gradual megaloblastic maturation with the marrow picture approaching normal on the tenth day of therapy. The maximum reticulocyte response (26.8 per cent) was obtained on the fifteenth day of therapy, after a total cumulative dosage of 30 mgm. of folic acid. On the sixteenth day the daily dose was increased to 10 mgm. to see if a secondary reticulocyte rise could be induced. This was not observed. On the fortieth day of therapy the red cells reached 4,000,000 per cu. mm. and the hemoglobin 13.0 grams. There had been a definite corresponding rise in total white cells and platelets.

Clinically, on the second day of therapy, the patient volunteered that the numbness of the extremities was definitely diminished with a very evident improvement in the subjective sense of well being; the vibratory sense and the Rhomberg were noted to be improved objectively after 21 days of therapy.

The clinical and hematologic responses are under continuing critical scrutiny in this and other selected patients.

It is of particular significance in evaluating the mechanism of this response to the daily parenteral administration of 2 mgm. of folic acid in pernicious anemia, that both bone marrow and peripheral blood have shown changes, which, in quality and timing, have been indistinguishable from those previously described in detail (Fig. III) following liver extract therapy.

*The solution used in these studies was prepared by dissolving 1 gram each of crystalline synthetic *L. casei* factor and sodium bicarbonate in 100 cc. of distilled water and then autoclaving.

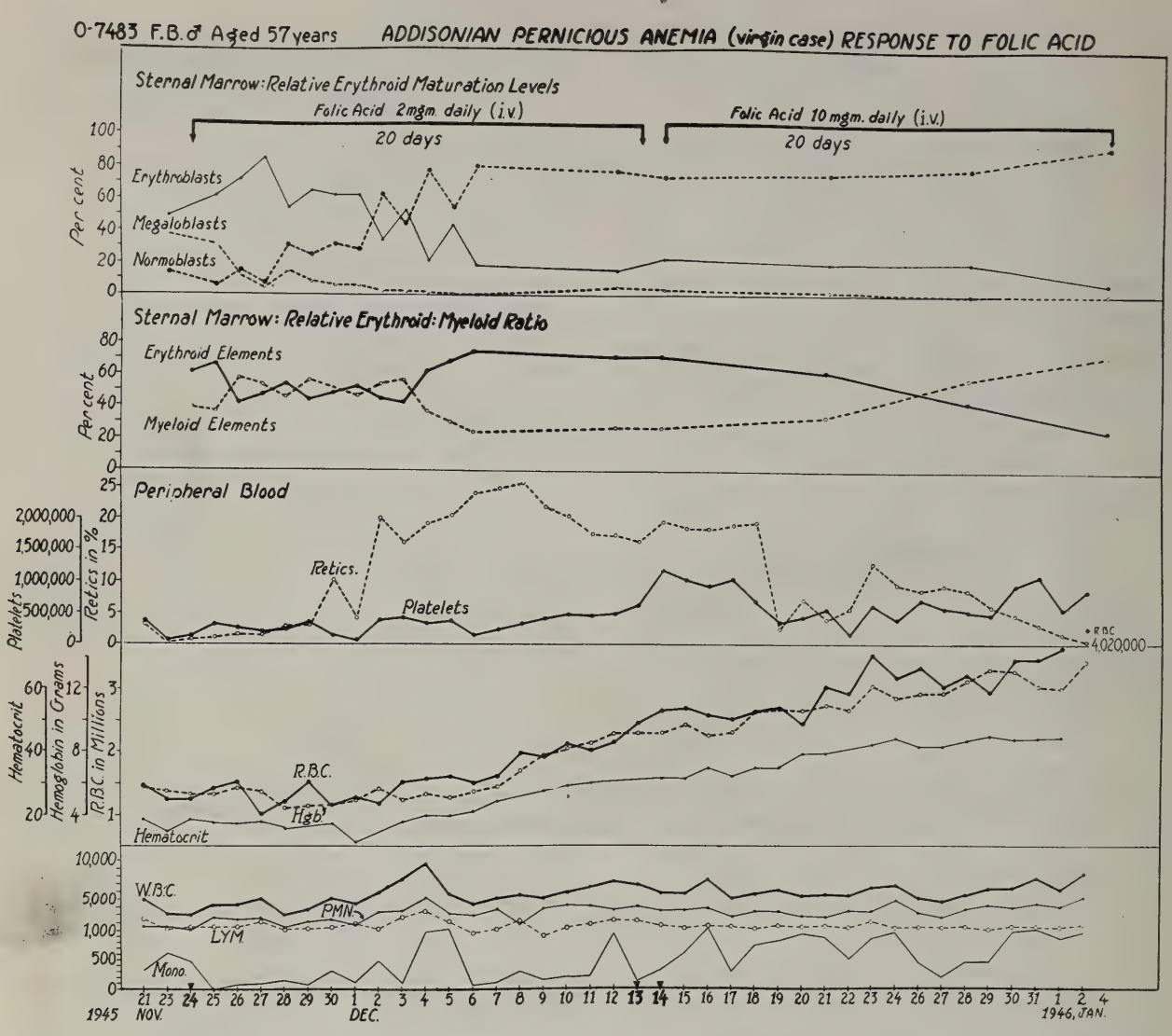


Fig. II. Note the maturation of marrow elements, reticulocyte crisis, rapidly progressive increase in erythrocytes, hemoglobin, white cells, and thrombocytes, and the identity of this response to that seen following optimum liver extract therapy (Fig. III).

Moore[19] has discussed quite fully the theoretical considerations which make it necessary to interpret conservatively at this time the precise identity of *L. casei* factor, synthetic, with the EMF in liver extract. The quantity of *L. casei* factor apparently necessary to promote optimum maturation of megaloblasts in the macrocytic anemias is considerably greater than has been demonstrated to be present in potent liver extract concentrates. That "folic acid" is neither the extrinsic factor[23] nor the intrinsic factor (Castle) per se, would seem to be suggested by the equal effectiveness of parenteral and oral administration. Further biological evidence on this point may be obtained from patients with pernicious anemia sensitized to liver extract.

II. Folic Acid Therapy in Patients Sensitive to Liver Extract.

The development of sensitivity to liver extract in certain patients has presented an increasing problem in our clinic, and elsewhere.[24] In three patients, who had been diagnosed as Addisonian pernicious anemia and had received parenteral liver extract therapy, hypersensitive intolerance developed within two weeks in one patient and not until after five years in another. It seemed desirable with the advent of synthetic *L. casei* factor to determine the tolerance of these patients to this anti-anemic principle.

Mr. N.T., aged 58 years, after five years of therapy first manifested sensitivity by repeated local inflammation at the site of liver extract injection, and later by typical anaphylactoid reactions associated with generalized urticaria. Mr. G.Y., aged 64 years, after 5 months of therapy reacted to all available commercial extracts with generalized urticaria and lacrimation. Mr. J.E., aged 74 years, within two weeks of the initiation of intensive liver therapy developed anaphylactoid reactions as well as moderate inflammation at the site of each injection. In all three patients intradermal skin tests were made using: (1) 1:10 dilution of two commercial liver extracts to which these patients had exhibited constitutional sen-

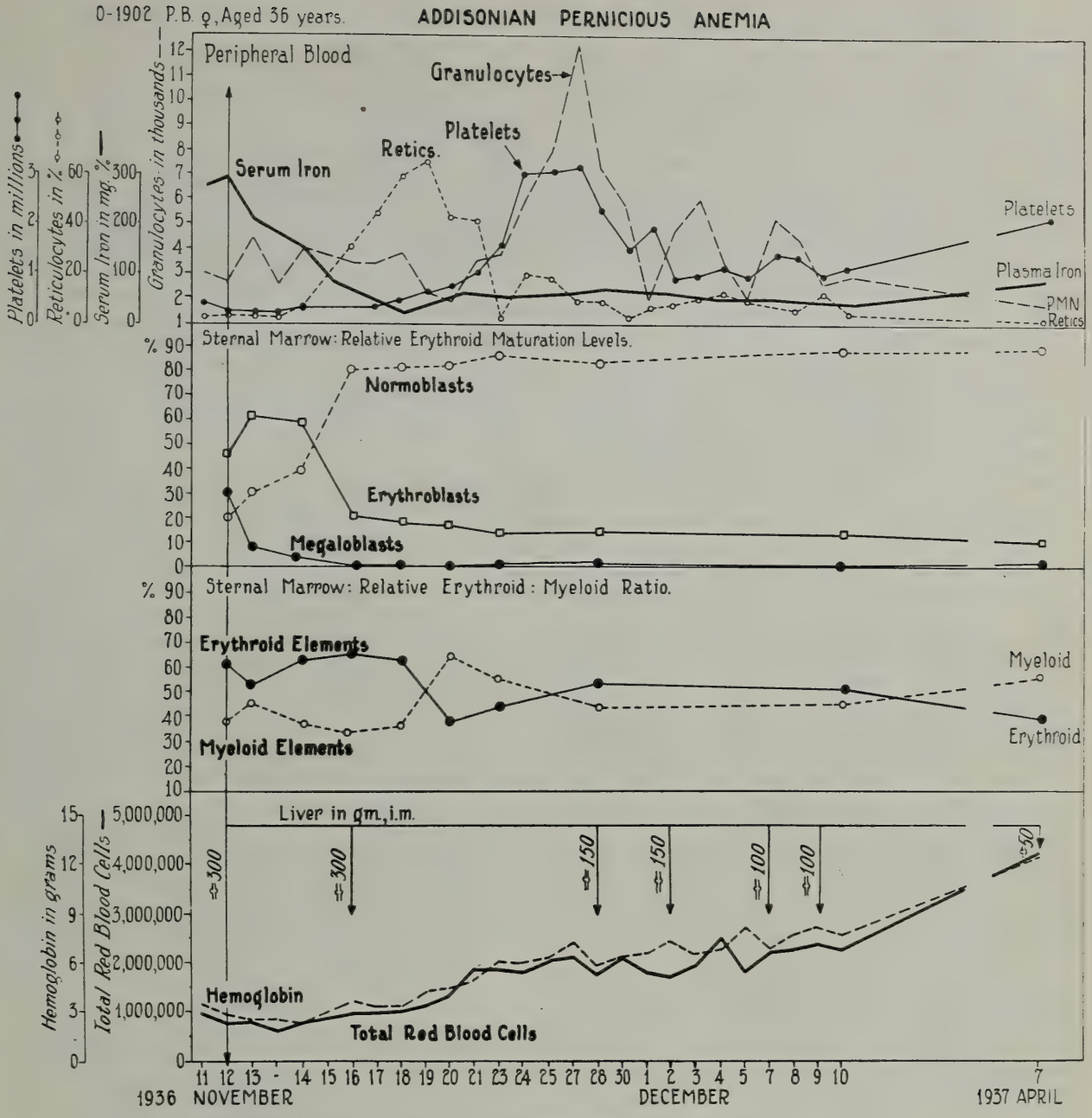


Fig. III. A classical response to EMF therapy using a potent liver extract.[22]

sitivity (Reticulogen, Lilly; and liver concentrate, Lederle); (2) folic acid (1 mgm. to 0.1 cc.); and (3) normal saline as a control. In each instance, the local reaction to the liver extracts was extremely marked, and in no instance was there any reaction to the folic acid greater than to normal saline. A normal anergic individual was used as a control for the intradermal interpretations. Each patient then received repeated intravenous injections of folic acid up to a maximum of 20 mgm. per dose daily and no sensitivity has been exhibited to this material to date.

III. Other Therapeutic Trials of Folic Acid.

Following the foregoing experimental and clinical observations we have used *L. casei* factor, synthetic, in selected patients showing a variety of types of anemia and/or leucopenia. As one would predict, on the basis of the mechanisms involved, folic acid (up to 50 mgm. i. v. daily) has not influenced the granulopenia of epidemic influenza nor the bone marrow or peripheral blood picture in idiopathic hypoplastic or myelophthisic anemias.

DISCUSSION

In analyzing the increasing volume and variety of both clinical and experimental studies with "folic acid", as derived from spinach[25], liver, yeast, other natural sources, and now, the synthetic *L. casei* factor[3], it becomes increasingly apparent that we are dealing with one of the more fundamental molecules essential to the normal metabolism of all cell types in marrow, and in young, actively growing cells and tissues generally, perhaps. In the absence of "sufficient"

L. casei factor due to extrinsic dietary deprivation, or with intrinsic interference in absorption or utilization, a more or less marked, specific or general, cellular inadequacy develops in mammalian bone marrow with the appearance of signs and symptoms associated with, and dependent upon, the extent of the individual's susceptibility. The availability in quantity of a pure synthetic product should greatly facilitate the prompt recognition and establishment of the true metabolic significance of this fraction of the vitamin B complex.

CONCLUSIONS

1. Abundant experimental evidence indicates a profound stimulatory effect of *L. casei* factor, ("folic acid") on leucopoiesis, erythropoiesis and thrombocytopoiesis, and on growth and nutrition in animals.

2. The work on nutritionally deficient monkeys in this laboratory, and elsewhere, indicates that "folic acid" fills a specific requirement for normal bone marrow function.

3. One case of Addisonian pernicious anemia is reported in which 2.0 mgm. of *L. casei* factor, synthetic, (folic acid) per day produced the maximum calculated reticulocyte crisis. The progressive rise in red cells and hemoglobin, the reversal of the bone marrow picture to normal, and the remission of clinical signs and symptoms seems, thus far, to parallel in all respects the response to liver extract therapy, as it has been observed in this clinic under similar conditions. This is in complete confirmation of Spies and Moore's observations.

4. In patients requiring continuous EMF supplementation to maintain a normal hematopoietic equilibrium, and who develop sensitivity to liver extract, it is suggested that synthetic *L. casei* factor may be substituted satisfactorily and safely.

5. The leucopenia of influenza and the panhematopenia of myelophthisic and idiopathic states have not been influenced favorably by folic acid administration, thus far, in our clinic.

BIBLIOGRAPHY

1. Spies, T. D.; Vilter, C. F.; Koch, M. B.; and Caldwell, M. H.: Observations on the Anti-Anemic Properties of Folic Acid. South, M.J., 38:707. 1945.

2. Vilter, C. F.; Spies, T. D.; and Koch, M. B.: Further Studies on Folic Acid in the Treatment of Macrocytic Anemias. South. M. J., 38:781, 1945.

3. Angier, R. B.; Boothe, J. H.; Hutchings, B. L.; Mowat, J. H.; Semb, J.; Stokstad, E. L. R.; SubbaRow, Y.; Waller, C. W.; Cosulich, D. B.; Fahrenbach, M. J.; Hultquist, M. E.; Kuh, E.; Northey, E. H.; Seeger, D. R.; Sickles, J. P.; and Smith, J. M., Jr.; Synthesis of a Compound Identical with the L. Casei Factor Isolated from Liver. Science 102:227, 1945.

4. Spicer, S. S.; Daft, F. S.; Sebrell, W. H.; and Ashburn, L. L.: Prevention and Treatment of Agranulocytosis and Leukopenia in Rats Given Sulfanilyguanidine or Succinyl Sulfathiazole. Public Health Reports 57:1559, 1942.

5. Kornberg, A.; Daft, F. S.; and Sebrell, W. H.: Production and Treatment of Granulocytopenia and Anemia in Rats Fed Sulfonamides in Purified Diets. Science 98:20, 1943.

6. Axelrod, A. E.; Gross, P.; Bosse, M. D.; and Swingle, K. F.: Treatment of Leucopenia and Granulopenia in Rats Receiving Sulfaguanidine in Purified Diets. J. Biol. Chem. 148:721, 1943.

7. Kornberg, A.; Taber, H.; and Sebrell, W. H.; Effect of the Lactobacillus Casei Factor ("Folic Acid") on Blood Regeneration Following Hemorrhage in Rats. Am. Jr. Physiol., 142:604, 1944.

8. Kornberg, A.: Daft, F. S.; and Sebrell, W. H.: Dietary Granulopenia in Rats Corrected by Crystalline L. Casei Factor. Proc. Soc. Exper. Biol. and Med. 58:46, 1945.

9. Mills, R. C.; Briggs, G. M., Jr.; Elvehjem, C. A.; and Hart, E. B.: Lactobacillus Casei Factor in the Nutrition of the Chick. Proc. Soc. Exp. Biol. & Med. 49:186, 1942.

10. Woolley, D. W.; and Sprince, H.: Nature of the New Dietary Factors Including Folic Acid Required by Guinea Pigs. J. Biol. Chem. 157:447, 1945.

11. Langston, W. C.; Darby, W. J.; Shukers, C. F.; and Day, P. L.: Nutritional Cytopenia (Vitamin M Deficiency) in the Monkey. J. Exper. Med 68:923, 1938.

12. Wilson, H. E.; Doan C. A.; Saslaw, S.; and Schwab, J. L.: Reactions of Monkeys to Experimental Respiratory Infections. V. Hematologic Observations in Nutritional Deficiency States. Proc. Soc. Exper. Biol. & Med. 50:341, 1942.

13. Saslaw, S.; Schwab, J. L.; Woolpert, O. C.; and Wilson, H. E.: Reactions of Monkeys to Experimental Respiratory Infections. VI. Spontaneous and Experimental Infections in Nutritional Deficiency States. Proc. Soc. Exper. Biol. & Med. 51:391, 1942.

14. Saslaw, S.; Wilson, H. E.; Doan, C. A.; and Schwab, J. L.: The "Vitamin M" Factor. Science 97:514, 1943.

15. Hutchings, B. L.; Bohonos, H.; and Peterson, W. H.: "Growth Factors for Bacteria." XIII Purification and Properties of an Eluate Factor Required by Certain Lactic Acid Bacteria. J. Biol. Chem. 141:521, 1941.

16. Waisman, H. A.; and Elvehjem, C. A.: The Role of Biotin and "Folic Acid" in Nutrition of the Rhesus Monkey. J. of Nutrition 26:361, 1943.

17. Day, P. L.; Mims, V.; Totter, J. R.; Stokstad, W. L. R.; Hutchings, B. L.; and Sloan, N. H.: The Successful Treatment of Vitamin M Deficiency in the Monkey with Highly Purified L. Casei Factor. J. Biol. Chem. 157:423, 1945.

18. Berry, L. J.; Spies, T. D.; and Doan, C. A.: A Note on the Influence of "Folic Acid" on Leukocyte Equilibrium in Malnourished Patients. South. M. J. 38:590, 1945.

19. Moore, C. V.; Bierbaum, O. S.; Welch, A. D.; and Wright, L. D.: The Activity of Synthetic Lactobacillus Casei Factor ("Folic Acid") as an Antipernicious Anemia Substance. I. Observations on Four Patients: Two with Addisonian Pernicious Anemia, One with Nontropical Sprue and One with Pernicious Anemia of Pregnancy. J. Lab. & Clin. Med. 30:1056, 1945.

20. Spies, T. D.: Personal Communication.

21. Moore, C. V.: Personal Communication.

22. Houghton, B. G.; and Doan, C. A.: A More Sensitive Bio-Titration of Optimum Erythrocyte Maturation in Human Anemic States. Am. J. Clin. Path. 11:144, 1941.

23. Castle, W. B.; Ross, J. B.; Davidson, C. S.:Burchenal, J. H.; Fox, H. J.; and Ham, T. H.; Extrinsic Factor in Pernicious Anemia: Ineffectiveness of Purified Casein and of Identified Components of the Vitamin B Complex. Science 100:81, 1944.

24. Bethel, F. H.: Sturgis, C. C.; Rundles, R. W.; and Meyers, M. C.: Blood, A Review of the Recent Literature. Arch. Int. Med. 76:239, 1945.

25. Mitchell, H. K.; Snell, E. E.; and Williams, R. J.: The Concentration of "Folic Acid". J. Am. Chem. Soc. 63:2284, 1941; and Folic Acid; Concentration from Spinach. J. Am. Chem. Soc. 66:267, 1944.

26. Darby, W. J.; Jones, E.: Treatment of Sprue with Synthetic L. Casei Factor (Folic Acid, Vitamin M). Proc. Soc. Exper. Biol. and Med., 60:259, Nov., 1945.

The myth that tuberculosis is nearing the point of being conquered has received two rude shocks of late. The first is the discovery of tens of thousands of unsuspected cases through mass X-ray procedures. The second is autopsy proof that the infection rate has not lessened proportionately to the decline in mortality. Eradication of the tubercle bacillus lies far ahead. Nevertheless it can and must be done.—Kendall Emerson, M.D., Ed. NTA Bulletin, Sept., 1945.

Some Psychiatric Notes on the War in the Pacific

HARRISON S. EVANS, M.D.

ANY psychological disorder is the result of an interaction of the individual and his environment. We know that the environment during childhood is of great importance in the formation of personality, with its strength and weaknesses. The environment is also important from the standpoint of precipitating psychological problems in the adult, whether it is so overwhelming that a so-called "Situational Reaction" is produced or whether it presents features that reactivate old, incompletely resolved conflicts.

The war in the Pacific has presented an environment that has been exceedingly traumatic to many personalities. As a result, there has been a great number of psychiatric problems. In the average general hospital they constituted 30 to 50 per cent of the hospital population.

It is the purpose of this article to discuss the environmental or situational aspects of the war in the Pacific and to show how they have brought about unfavorable psychological reactions in many soldiers. The problem is immense and has many ramifications. Therefore this presentation can only be but a glimpse of the whole. But, nevertheless, it was felt that the observations and impressions of a psychiatrist in a general hospital, which, over a period of about a year, had approximately 3,000 patients that were either on the Neuro-psychiatric Service or were seen in consultation by this Service, would be worth recording.

PSYCHOLOGICAL ADJUSTMENTS TO THE ARMY IN WAR TIME

The psychological adjustments that every inindividual—enlisted man and officer—must make upon entering the Army in war time are not of minor importance, for upon these adjustments depend his future value as a soldier. Of necessity his manner of living, his immediate purposes and goals, his attitudes must be modified. To an American, civilian life can be very rich and full. The everyday frustrations, denials and hardships that impinge upon the ego and cause pain and distress are offset and mental poise is maintained through an innate sense of control, brought about by a feeling that there is power of choice and direction, that one's life is to some extent one's own.

In the Army, an authoritative, regimented life is a necessity. Within certain limits each individual life is subordinated to the common good. This brings about an intensification of denials and frustrations (ego conflicts) that heretofore had not been experienced in such a degree or in such a setting.

At the same time there is an associated decrease in compensatory outlets, ordinarily present in civilian ilfe, to offset these various traumata. It is this very impact of the ego with such intensified reality conflicts that demand adjustment in one's mental life.

Thus far the conflicts incident to a changed reality, only, have been discussed. But division of psychic life is purely arbitrary. Various instinctual claims, such as the satisfaction of the various appetites and the release of aggressive tension, although an inner source of conflict to the ego, also are solved directly or indirectly through the ego's adjustment to reality. Consequently, with a disturbed reality situation, such as occurs upon entering the Army, the solution of instinctual claims also becomes disturbed. Thus the ego is really in conflict from without and from within.

The usual and normal reactions to these conflicts, incident to entering the Army, are feelings of increased insecurity and of decreased self-value. Mild anxiety, emotional depression and irritability are common subjective phenomena. To offset these real threats to one's integrity as a personality, recourse to certain psychological defense mechanisms is taken. These can be discussed under: (1) **Identification**; (2) **Substitution**; and (3) **Narrowing of Perspective and Interests.**

1. **Identification** is a mental mechanism by which one applies to oneself certain attributes that really belong to another person or to a group. Most people who enjoy the theatre do so by identifying themselves with the hero or heroine, which enables the individual, for the time being, to lose completely his own role as an unromatic, unimportant individual. This permits

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one to get away from the drab realities of life. Another example of identification is the pride that people take in going to a big university. The attributes of greatness which apply to the university, such as its learned professors, renowned athletes, etc., are applied to the individual through the mechanism of identification and in this manner the individual develops a sense of increased value and importance.

This same mechanism is used in the Army. The recruit soon learns to identify himself with his unit or his branch of service and thereby develops a feeling of strength and value that arises out of the collective strength and value of the unit or branch of service to which he belongs.

2. **Substitution** is an important mechanism in adjusting to the Army, although it is a more conscious, deliberate process than identification. Substitution consists chiefly of exchanging for the goals and rewards of civilian life the rewards and goals of Army life, such as excitement and adventure, seeing new lands of interest, getting various decorations, being promoted or serving out of patriotic reasons the the country that one loves. That this is successfully done in those soldiers who adjust well, is testified to by the dropping out of consciousness the various pursuits, interests and goals one had in civilian life. The meaning of life as a civilian becomes vague and distant and can be conjured up only with difficulty.

3. **Narrowed perspective and interest*** refers to a restriction of ego interests. The successful soldier must learn to be primarily concerned with his own task and that of his unit's. For reasons of military security he can not know over-all plans or how he and his unit fit into them. He must learn to accept his role as a pawn in a gigantic game of chess. To save himself from developing a sense of complete insignificance and unimportance, he must learn to focus his interests and attention on the daily task, live each day at a time—"live in day tight compartments" —and accept the simple rewards that come to him and his unit. Through this very narrowing of perspective and interest, his own task becomes more important, assumes greater size, so that his and his unit's value is enhanced. I believe it is impossible for the average soldier or officer to retain his orientation if he tries to see himself in light of the whole military effort, for there are not enough opportunities to offset the nihilistic effect of such a comparison.

*Anna Freud, in her book, "The Ego and the Mechanisms of Defense, 1942, "The Hogarth Press, 37 Meckenburgh Square, London, pp. 100-113, discusses "Ego Restriction," which occurs when something painful is met in life. The painful object is relegated to the periphery of the consciousness and maintained there by restricting the ego interests, which are focused on some new object that can be handled and will bring more pleasure to the individual. In a sense this is what I am referring to when I speak of a narrowed perspective. The denial of civilian goals and rewards and the overwhelming insignificance of the average soldier are extremely painful reality experiences. They, therefore, are relegated to the periphery of consciousness and one's perspective and interests are narrowed and focused on the goals and rewards at hand.

THE WAR IN THE PACIFIC

A. The Setting: The war in the Pacific has had many characteristics quite peculiar to itself. It has been a war in which isolation has been an outstanding feature. Each battle area, each base, was an outpost, a place which, before the war, the average civilian had never heard of. It was fought and lived in steaming hot jungles or on barren, rock strewn islands. Large land campaigns, in the European sense, were unknown. Fighting, especially in the early part of the war, had a distinctly individual coloring, reminiscent of the early days of Indian warfare in America, with the long patrols through woods and jungles, ambushes, nights alone in a "fox-hole".

After a base was taken and service troops established themselves to furnish supplies for further, advanced operations, the full reality of what living in the Pacific was like became increasingly clear. The newness of a strange land soon wore off. The enchantment of the Pacific Islands, which had been built up in many a solmind, dissolved in the humidity that bathed each island. There were swamps, mud or dust, insects, tropical disease, a monotonous, enervating heat, long protracted rainy seasons and a native population that was neither attractive nor educated and which did not have the marks of a civilization or culture which the soldier could feel he was a part of.

To add to the sense of isolation and feeling of loneliness there was no place to go. There were no villages, no recreational centers, no dances. Enlisted men had no contact with women, no opportunity for social outlets. And because of the urgency of war, travel was restricted. Consequently most of the troops didn't even get leaves to metropolitan Australia. To work and to one's tent and back to work again was all that one had to look forward to, day in, day out, month in and mouth out. Time lost all delineation. Days merged into weeks and weeks into months so that the past had a sameness, a completely unmarked sameness that made one feel lost in a sea of time. Holidays, Sundays, Winter and Summer were all the same. When something happened, whether it was a friend that left for home or when a campaign was finished, it could not be placed in time a few weeks later. It could have been six weeks or six months ago. Disorentiation in time was no pathological phenomenon in the Pacific.

Inevitable periods of greatly reduced activity or actual inactivity for varying lengths of time constituted another hazard to mental health. Many found an escape in work which had served to give some meaning to their existence. But when this outlet was not available, restlessness,

tension and disorentiation were difficult to combat. Frequently soldiers would start drinking, or, feeling that they were not essential anyhow, would absent themselves without leave and thus get into disciplinary difficulty.

There was little or no opportunity to derive emotional stimulation from various victories as there was in Europe. There, cities and peoples of the same race, of the same culture and of related historical significance were being liberated. Progress was measured in concrete terms, in observed and fully appreciated facts. In the Pacific, on the other hand, liberating Guadalcanal, Saidor, Hollandia, Biak or Morotai, strategically significant as these victories were, could bring little sense of satisfaction to the average soldier. There was no city, no evidence of civilization as most soldier's know it and certainly no cheering people—just more of the same jungle, the same heat and the same isolation. Even though such victories did bring the troops nearer home via Manila and Tokyo, this was a dim and most unrealistic reward since it looked like such fighting could go on for months and years under the same conditions.

Another feature of considerable importance was the prolonged period that troops had to remain in the Theatre in such an isolated environment. Because of the acute need for manpower no effective policy could be worked out whereby the men could feel that after 18 months, 24 months, or even 30 months overseas they could go home. Attempts were made to solve this problem and various plans for rotation were set up, creating hope of relief and giving something definite to which one could look forward. But then such plans would be changed on different occasion. Probably the needs of the war dictated that they be changed. Nevertheless, this served to create disillusionment and actual loss of confidence in ever getting a definite relief policy. As a consequence a complete sense of helplessness, of being trapped, permeated the feelings of many troops. There seemed to be nothing that one could really look forward to.

Another aspect of living in the Pacific that was hard was the denial of simple oral gratifications. Cold drinks, fresh foods, restaurants where one could sit down and order a cup of coffee or sandwich, were non-existent. Fresh foods, including eggs, meat and salads, were a rarity. And of course fresh milk was not to be had at any time.

Thus one sees that for the average soldier the war in the Pacific frustrated nearly every psychobiological need—social, recreational, and instinctual. Added to this frustration was the fact that it was so prolonged, with the uncertainty that it might go on and on indefinitely. Such a setting constituted psychological traumata of major importance.

B. The Psychological Effects: In the presence of the psychological traumata just discussed, the defensive measures, established upon entering the Army, were vulnerable and in many instances broke down completely. Identification became weakened and often failed entirely. This occurred because many units had such an uninspiring, drab role to play. Frequently there was nothing in the life of the unit, as a whole, to stimulate love, admiration or pride. Therefore the opportunity to gain a sense of strength, of importance and of value from these attributes that should reside in the unit was lost. This left the individual psychologically isolated and alone. The reality of his situation was not softened in any respect for there was nothing to lift him above the commonplace of his everyday life.

Substitutive outlets were virtually non-existent. There were few heroic deeds to perform for the many non-combat soldiers. There were no admiring peoples to cheer one along the way. Promotions were available for a limited number. The average soldier soon began to feel that he had just about given up everything in life with little given in return.

The narrowed, highly focused perspective was lost when the daily task no longer possessed its former value to the individual, when there was nothing pleasurable or gratifying to work for. The ego lost its tone, so to speak, and was no longer able to maintain an alert defense against painful and interfering thoughts. It lay patulous and subject to every emotional current. Former pleasures and life goals, that had been restricted and surpressed, flooded back into consciousness. Brooding over them, wishing for them, only caused pain for which there was no relief. The defense barriers were down and yet there was no ecape from the situation that made these barriers so very essential.

One result of this dissolution of defensive mechanisms was the building up of intense hostility for which there was no longer any outlet in constructive channels. This hostility was the dynamic force underlying many of the clinical pictures that were seen. It was characteristically manifested in a change of attitude so that problems of attitude were the first clinical problem met. There were griping, irritability, disinterest and lack of cooperation. This constituted a period of disciplinary stress and required firm but tactful and understanding management by the commanding officer if a catastrophe in a unit were to be averted, for such a reaction is "contagious". This entailed much personal effort and interest on the part of the company commander. If the men could have their faith reestablished by believing in their officers, who needed to demonstrate that they, themselves, were thoroughly oriented and appreciated their purpose in the Army; if they could have some evi-

dence that others were really interested in them and appreciated them, whether through planning organized athletics, building an attractive outdoor theatre, or establishing other specially contrived outlets, then the personality disorder would perhaps progress no further than one of poor attitude and minor disciplinary difficulty.

However, in some cases the ego forces were so severely weakened that they were unable to restrain the objective threats of loneliness, isolation and deprivation. Neither could the pressure of the inner hosility be restrained. As a result a new stage of personality decompensation appeared. This was often characterized by a rather vague clinical picture that had many features associated with a psychoneurosis. There were fatigability and indolence. There were emotionalism, tension and difficulty in sleeping. Somatic phenomena such as lightheadedness, palpitation, flushing, hyper-ventilation, dyspnea and vasomotor instability, although due to the anxiety incident to the impending failure of the ego, created further anxiety and concern about one's physical well being. Such syndromes can only be differentiated from a psychoneurosis, if at all, by taking a careful history to determine previous neurotic traits or failures. We found many comparatively healthy personalities developing these reactions after prolonged tropical service.

To avoid using the diagnosis of psychoneurosis indiscriminately in classifying these neurotic-like pictures, two diagnostic terms were suggested by the Chief Surgeon's Office to classify these reactions. They were Simple Adult Maladjustment and Situational Reaction. The first was used when the individual had a reasonably healthy pre-clinical personality and when the current picture showed in particular a bad attitude and free expression of resentment. This diagnosis implies a conscious, almost deliberate unwillingness to adapt to the situation. When such a diagnosis was made, the problem was not handled through medical channels but, instead, through administrative channels. It is my own feeling that this diagnosis should be used with considerable care.

The Situational Reaction, clinically, resembles a neurotic state. The chief difference is the comparatively good pre-clinical history and the fairly prompt recovery once the individual is relieved of the stress-producing situation.* The situation must consist of long and arduous duties with unusual responsibility or prolonged combat. This diagnosis does give full credence to the situation, which is important, but it tends to ignore the dynamic interaction of the personality with the situation. However, it emphasizes a fact that is often overlooked, namely, that there are situations that will break down the sturdiest individual, who has never in the past nor likely will again in the future display so-called neurotic traits.

In many instances the stage of decompensation, variously known as Simple Adult Maladjustment or Situational Reaction is a fluid one and does not reflect a fixed patterned response on the part of the individual. On many different occasions, too many not to be without significance, patients were admitted to the disturbed wards grossly psychotic. Upon reviewing their previous records one would find that the patient had had several previous hospitalizations at which time the diagnosis of psychoneurosis, simple adult maladjustment or situational reaction had been made. Such experiences should caution one against being too superficial in one's interpretation of symptoms. Complaints, whatever their nature is, have significance. The question is, how serious is the problem, whither is it tending, how strong an ego does the individual have and what is the best method of handling the problem. Such decisions require the greatest clinical skill and also careful psychological testing, which was not generally available, and even then mistakes will be made. The important point is that a diagnostic term, at best, is often a poor indicator of what is taking place dynamically within the patient in many instances. This should be kept in mind to avoid too rigid interpretation of symptoms and unwise decisions.

The last stage of decompensation was one of a frank psychosis. Atypical pictures were common. Many showed fairly short maniacal reactions. The expression of the pent-up hostility was demonstrated by destructive behavior, cursing, nudity, and disregard for officers who represented all of the prohibitions and frustrations that had been endured. Although depressions were fairly common, suicide attempts were rare. This suggests that many of them were reactive in nature, sort of an ego poverty due to prolonged denial, and not a deeply motivated, self-destructive reaction.

TREATMENT

Shock treatment, either electro-shock or metrazol, was used extensively in the psychoses. In some instances insulin shock therapy was used. The results, in the acute reactions, were almost universally spectacularly successful. Often two or three shock treatments would render an acutely disturbed maniacal patient lucid and cooperative. It is certain that shock therapy prevented many deaths by bringing about prompt recovery in highly disturbed cases. It also made the general over-all care of the patients easier by reducing the noise and the usual necessary struggling with any disturbed patient.

Recreational therapy in the form of volley ball, soft ball, walks and various programs furnished by the Red Cross was used extensively. Occupational therapy was used quite extensively,

*Actually this latter criterion is true for many psychoneurotics seen in civilian life.

although trained therapists were not ordinarily available. Nurses or physical therapists aids were often employed successfully as substitutes.

Therapy for the minor psychiatric problems was scarcely adequate. There were too few trained therapists with a good understanding of dynamic psychiatry. Furthermore, all psychiatrists were greatly overworked. Special neuropsychiatric hospitals were established to treat these problems. As a whole they did an outstanding job. The greatest task was for the psychiatrist to keep an open mind and not to be swayed by pressure to return men to duty nor to be too lenient in recommending evacuation. Problems of behavior and attitude tended to arouse resentments, not only in medical officers as a whole, but in psychiatrists, too. This made it difficult to maintain a healthy, objective outlook or to avoid expressing punitive tendencies. Psychiatry of attitudes and behavior disorders was something that was new to most psychiatrists and for this reason they were not too well equipped to deal with such problems. This is an important field and indicates an orientation that is very necessary to every military neuropsychiatrist.

SUMMARY

Psychiatric problems have been of major importance in the Pacific War. The great number of non-combat neuropsychiatric casualties can be attributed directly to the conditions imposed by the geography, climate, isolation, living conditions, transportations difficulties which restricted leaves, and the lack of manpower that prevented adequate rotation. The psychodynamics of the individual soldier's reaction to such traumata are of considerable importance. It has been pointed out that the normally developed defense mechanisms, erected in an effort to adjust to Army life, become especially vulnerable to the situations that were met in the Pacific Theatre. The stages of personality decompensation consequent to the breakdown of these psychological defenses have been discussed.

The endurance and patience of the average soldier, plus an alert psychiatric program in the Theatre, have kept psychiatric casualtis within reasonable limits. It is certain that the Pacific War will go down in history as a triumph of supply and tactical and strategical ingenuity; it also should go down in history as a triumph of human adaptability to conditions that were harsh and uncompromising.

Among white women the death rate from tuberculosis is higher in rural areas than in urban areas. The rural rate exceeds the urban rate for all ages, except the very youngest.—Jacob Yerushalmy, M.D. & Charlotte Silverman, M.D., Am. Rev. Tbc., May, 1945.

KEEPING UP WITH MEDICINE

THERE are great advantages in living out in the country where the air is pure and free from dusts and traces of things to be avoided.

* * *

IT is possible by selection of the correct natural foods to correct all of the deficiencies and excesses of our diets.

* * *

SUGAR has a double-barreled effect in contributing to a reduced intake of vitamins and minerals since it contains none and, by satisfying hunger rapidly, reduces the amount eaten of foods containing these essentials.

* * *

THE experimental use of androgen therapy in **angina pectoris** has frequently been attended by gratifying results—too frequently to be accidental.

* * *

ACUTE brucellosis has been confused with tuberculosis, pneumonia, malaria, typhoid, or influenza; and less often with bronchitis, rheumatic fever, cholecystitis, pyelitis, appendicitis, arthritis, bursitis, and osteitis.

* * *

IN nasal allergy, the use of nasal discomfort is indicated even though the relief is often temporary.

* * *

THE most valuable aid to the physician in the appraisal of the state of nutrition of his patient is the therapeutic test.

* * *

THE gathering of isolated analyses of the medical records of twins is extremely valuable.

* * *

LONG continued contact with low concentrations of primary irritant will dehydrate the skin or abstract its fats or its watery content, causing chronic fissured eczema.

* * *

EIGHTY per cent of all occupational dermatoses are caused by primary skin irritants and not by allergens.

* * *

ARTHRITIS is a constitutional disease requiring complete and continued treatment from the start.

* * *

UNLESS some other diagnosis is incontrovertible, every woman with a chronic right-sided lower abdominal pain should be put on a diet to overcome her constipation and this should be successfully accomplished for at least three months before any surgical interference is even considered.—J.F.

Fatal Case of Sodium Nitrite Poisoning

MELVIN OOSTING, M.D.

THE possible toxic effects of the nitrites have not hindered their widespread use in cardiovascular diseases. Fortunately most patients tolerate the usual therapeutic doses relatively well, although cardiovascular collapse may occur from as little as 0.65 mg. of glyceryl trinitrite.[1]

Poisoning of infants, from nitrite induced methemoglobinemia and circulatory collapse, has been reported. Recently, Comly[2] reported a case due to nitrates in well water. Bismuth subnitrate may be reduced to the nitrite by the intestinal flora which in turn is absorbed producing circulatory collapse and death in those infants ill with diarrhea.[1]

Most reported cases of fatal nitrite poisoning are accidental. Sinigar[3] reported a case of a 16 months infant who was given a dose of 3½ grains of sodium nitrite instead of sodium citrate. Palmer reported a case in a 39 year old male who accidentally took sodium nitrite for epsom salts. McQuiston[5] reports three cases involving a family who mistook sodium nitrate for table salt and as much as 4.2 grams were recovered from one stomach contents. Naidu and Rao[6] report a sixth case of a 15 year old boy from whose stomach contents, 86 grains of potassium nitrite were recovered. Padberg and Martin[7] report three cases of fatal poisoning of elderly men who accidentally used sodium nitrite believing it to be sodium chloride.

REPORT OF CASE

A two year old white male (E. F. A-27-U) was admitted to the emergency ward of the Miami Valley Hospital in complete circulatory collapse. The blood pressure could not be determined, the pulse was weak and thready, he appeared to have great air hunger, there was deep cyanosis, especially of the extremities and face. In spite of immediate administration of stimulants and oxygen, he died in a few minutes after admission.

A history of having been found in a semiconscious state was obtained. Further investigation indicated that the child might have swallowed a number of his grandmother's pills given to her on prescription of her physician, for hypertension. These were later determined to be 2 grain sodium nitrite tablets.

Autopsy performed 16 hours after death showed a generalized brownish cyanosis, a thymus gland weighing 50 grams, a quiescent apical caseous pulmonary tuberculosis, generalized abdominal lymphadenopathy, hypoplasia of adrenal glands and 20 enteric coated partially digested tablets in the stomach and intestines. Chemical examination proved these to contain nitrites and a qualitative blood analysis showed a high nitrite content. A diagnosis of acute nitrite poisoning associated with a status thymicolymphaticus syndrome was made. Unfortunately no quantitative chemical blood analysis was made.

*From the Diagnostic Laboratories of the Miami Valley Hospital, Dayton, Ohio. Submitted November 19, 1945.

The Author

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DISCUSSION

This report is submitted to add to the few reported cases of nitrite poisoning and to call attention to the dangers associated with the use of both nitrites and nitrates. The accidental swallowing by children of pills prescribed for adults, with fatal consequences, is by no means uncommon.

Possibly the associated finding of the status thymicolymphaticus syndrome in this case was a contributory factor in the fatality. However, the number of ingested nitrite tablets was sufficient to cause death.

The treatment of cases of nitrite poisoning with its resulting methemoglobinemia and circulatory collapse is often not of the best. Usually epinephrine or some stimulant is given and oxygen therapy instituted. Methylene blue should be used to overcome the methemoglobinemia plus oxygen and strychnine should be given to overcome the circulatory collapse.

SUMMARY

A case of fatal nitrite poisoning is reported and the need for caution in prescribing large numbers of nitrite tablets is implied.

BIBLIOGRAPHY

1. Goodman and Gilman: The Pharmacological Basis of Therapeutics, 1941, p. 555, The Macmillan Co., New York.
2. Comly, Hunter H.: Cyanosis in Infants Caused by Nitrates in Well Water. J.A.M.A. 129: 112-116, Sept. 8, 1945.
3. Sinigar, H.: Cases of Poisoning by Sodium Nitrate and Boric Acid. The Lancet, 193: 162, Aug. 4, 1917.
4. Palmer, Arthur H.: Fatal Poisoning by Sodium Nitrite. Med. J. of Australia, 2: 113-114, July 22, 1933.
5. McQuiston, T. A. C.: Fatal Poisoning by Sodium Nitrite. The Lancet, 2: 1153-1154, Nov. 14, 1936.
6. Naidu and Rao: Case of Nitrite Poisoning. British Med. J., 1: 1300, June 27, 1936.
7. Padberg, Louis R., and Martin, Thomas: Fatal Cases of Sodium Nitrite Poisoning. J.A.M.A. 113:1733, Nov. 4, 1939.

Battle Wound of the Thigh Complicated by Gas Gangrene In a Case of Hereditary Hemorrhagic Thrombasthenia

RUSSELL L. SHIVELY, M.D.

THE practice of surgery in the military service usually involves patients who are in good physical condition and can withstand very severe injury. The finding of a wounded soldier who is a known bleeder is unusual. After this soldier was wounded the family history became a matter of extreme interest and importance. Constant nursing care and vigilance on the part of the surgical staff was required in order to avoid a fatality. The wounded soldier knew the presence of a hemorrhagic diathesis in his family but did not divulge the fact to the army at the time of induction. He escaped injury in three major campaigns but was wounded in the fourth during the occupation of France.

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CASE REPORT

A 20 year old white infantry soldier entered the hospital with a diagnosis of compound comminuted fracture of the right femur which was severe. It was noted on his field records that he had a tendency to bleed. He was wounded in the upper right thigh by a mortar shell fragment on July 11, 1944, in action against the enemy near Le Desert, France. First aid was rendered on the battle field immediately and the patient reached the battalion aid station within a few minutes after being struck. He was given ½ gr. of morphine tartrate, 2 gm. of sulfadiazine, two units of plasma, and the leg was immobilized for evacuation to the clearing station. At the clearing station he received oxygen, two units of plasma, ¼ gr. of morphine sulphate, 500 cc. of blood and was placed on 1 gm. of sulfadiazine every 4 hours.

Hemorrhage was further controlled and he was sent back to a field hospital where his B. P. was found to be 40/0 and the pulse rate 130 per minute. Here 1,500 cc. of blood, 500 cc. of plasma, oxygen and 1 cc. of tetanus toxoid were administered, followed by 20,000 units of penicillin in 2,000 cc. of 5 per cent glucose in n. saline. The B. P. was found to be 86/42 and as he gradually came out of shock he was given an additional 500 cc. of blood and 1,500 cc. of saline and glucose. Hemorrhage was again controlled and the B. P. came up to 104/60. On July 12 he received 20,000 units of penicillin with saline infusions every 4 hours for 6 doses. Sulfadazine, therapy was continued. At the end of the this day the B. P. was 96/48 and the P. 88. July 13 he was improved and the beeding had apparently been brought under control as the bandages were not disturbed. The progress notes for the next three days were lost en route to a general hospital in the United Kingdom. The patient states that he received several transfusions, the bandages were reinforced, he continued to take pills, and received painful shots in the buttocks during his trip from France to England.

The soldier entered this general hospital on July 18, 1944. He was placed on the seriously ill list and was given 500 cc. of blood on admission. He was nearly exsanguinated as the RBC was 1,610,000 and the Hb. 34 per cent. The clotting time was 4 min. and the bleeding time 14 min. The oral temperature was 100° F. and the B. P. 112/60 after the first transfusion. A bloody, foul smelling plaster spica cast was removed revealing a wound 4x3 inches on the anterior upper right thigh and another 2x3 inches on the posterior aspect. The wounds were foul smelling and contained excessive slough, maggots and old blood.

Laboratory and X-ray: The X-ray plates of July 18 showed a markedly comminuted fracture of the entire upper 1/3 of the right femur. Culture of the discharge showed the presence of Clostridium Welchii, Clostridium sporogenes, A. Hemolytic streptococci and Non-Hemolytic staphlococcus aureus. Blood studies were normal except for a persistent anemia, in spite of many transfusions, a low white count and prolonged bleeding time.

Progress in Hospital: On July 19, a diagnosis of gas gangrene was made which developed in spite of the fact that penicillin and sulfadiazine had been continued. A high guillotine amputation of the right thigh was done and the control of hemorrhage was a great problem during and after the operation. Repeated hemorrhages from the amputation stump on July 22 and 26 required ligation of tiny vessels and packing with pressure. Oozing continued and could not be controlled.

On July 30, the right external lilac artery was ligated using the extraperitoneal approach. Hemorrhages again occurred Aug. 1, 2, 3 and 4, regardless of the continuous pressure dressings applied to the stump. The dressing was changed under anesthesia on Aug. 7 when the bone was found to be necrotic and a foul discharge of pus and blood noted around the drain. Aug. 8, the dressing over the abdominal incision became foul smelling and the soldier complained of pain and pressure in his right lower quadrant. When the dressing was removed the incision was found to have disrupted under pressure of hemorrhage. A retroperitoneal hematoma was evacuated and the wound drained.

From Aug. 8 to Sept. 20, 1944, progress was very slow but the soldier continued to hold his own and did not have a severe hemorrhage. The

Submitted November 16, 1945.

bandages had to be reinforced several times and were always discolored with blood. During this period he received several transfusions, iron and liver therapy, highly nourishing foods, massive doses of vitamin C together with oral administration of multi-vitamins and excellent nursing care. The stump showed some tendency to heal but the abdominal wound continued to ooze blood and showed little progress. On Sept. 20, inspection of the stump revealed necrosis of the neck of the femur and gangrene of some of the soft tissue. Four days later the gangrenous tissue was widely excised and the necrotic neck of the femur removed. The dressing had to be reinforced the following day.

On Sept. 29, he suffered a gross hemorrhage and went into shock. More gangrenous tissue was removed and sutures placed to control active bleeding. Later the same day, after several blood transfusions, he was returned to the operation theater because bleeding continued. The remainder of the necrotic femur was disarticulated since the principal hemorrhage appeared to arise from the hip joint. When the ligamentum teres was clamped the real hemorrhage stopped but oozing continued elsewhere.

Fracture of the acetabulum was found and bone wax was used in a futile attempt to stop the oozing through the fracture line. The acetabular fossa was packed tightly with gauze. Heavy silk mattress sutures were placed across the stump incompletely approximating the skin over a large gauze pack and pulled very tight. Rubber tubing was used to protect the skin against the cutting sutures. The oozing stopped and the stump became fairly dry. We found this method of applying pressure very good and it was used on later occasions in this case. Oozing occurred around the sites where the sututres penetrated the skin. A pressure sore developed on his left heel which bled continuously until controlled by pressure bandages. The dressing on the stump was removed Oct. 3. A certain amount of oozing occurred which was controlled by pressure dressings using the same silk sutures described above.

Hemorrhages occurred again Oct. 10, 14 and 18, which were controlled by deep sutures and pressure dressings on each occasion. The bleeding was alarming on Oct. 18 and it was necessary to ligate the right obturator vessels for its control. There was no further bleeding until the dressing was changed on Oct. 21 when it became necessary to ligate the muscular branch of the internal pudendal artery. He improved rapidly after the beeding stopped, gained weight, the wounds began to look better and the patient's mental outlook became encouraging. He was now receiving massive doses of vitamin C intravenously and we felt the therapy beneficial in stimulating the healing process. He returned to the U. S. Nov. 7, 1944, by air. At the time of his departure the blood picture was normal except for a bleeding time of 10 minutes. The abdominal wound had healed and the stump looked healthy but a small superficial graunlating area remained.

From the date of the original injury on July 11, 1944, to the date of his return to the U. S. on Nov. 7, 1944, he received 59 blood transfusions and an equal amount of plasma and saline infusions. He survived 21 serious hemorrhages, recovered from shock 10 times, withstood 16 operations (five of which were of a major nature), and was given an anesthetic on 16 different occasions in 102 days.

Family History: The soldier has four sisters, four brothers and a mother living. None of the female members have any bleeding tendencies. All of the brothers have a tendency to bleed profusely when injured. The father died at the age of 65 years of a cerebral hemorrhage. A more detailed history as regards the bleeding tendencies of his brothers is as follows:

No. 1—age 42 years "bruises easy" and when subjected to trauma ecchymosis appears under the skin and the discoloration lasts a month or more. He has suffered tiny cuts while shaving and uses cigarette paper and pressure for at least one-half hour in order to control the oozing.

No. 2—age 38 years cut his forehead on a broken bottle and had to be taken to a hospital when ordinary attempts failed to control the hemorrhage. He was given several transfusions of whole blood and remained in the hospital for a period of five weeks. He, too, suffers ecchymoses following trauma that stay discolored for a prolonged period of time.

No. 3—age 27 was struck over the left eye while playing hockey and received a small laceration of the skin. He was taken to a physician who used clamps but this did not control the bleeding. Next several close stitches were taken, hemostatics applied and prolonged pressure brought the bleeding under control.

No. 4—age 25 suffers alarming nose bleeds and ecchymoses following trauma. He was given a medical discharge from the CCC because of his bleeding tendencies.

The past history of the soldier herein described is equally striking. He had never been operated upon prior to being wounded on July 11, 1944. His first injury was when he was about 15 years of age. At that time he cut his left thumb while cleaning rabbits. The bleeding was not controlled by ordinary measures and he had to consult a physician who sutured the laceration without success. He then stitched the wound and used prolonged pressure in order to bring the bleeding under control. The soldier states that hemorrhage occurred again when the sutures were removed and it was necessary to employ hemostatics and pressure. He gives a history of occasional nose bleeds when overheated and on several occasions had to consult a physician who would resort to packing. He had his right third molar extracted while in the CCC and had to be taken to a hospital because of undue hemorrhage. While in the hospital he received eight blood transfusions and was confined to his bed nearly one month. He was finally given a medical discharge from the CCC and was labeled a "Bleeder". The author found it necessary to use small needles when giving intravenous therapy and firm pressure was always exerted upon the puncture site following the extraction of the needle.

DISCUSSION

A diagnosis of hereditary hemorrhagic thrombasthenia is established in this case by the prolonged bleeding time (ranging from 9 to 14 min.), the absence of purpura and the familial tendency to bleed excessively in the presence of normal blood coagulability. The absence of the bleeding tendency in the female members of the family is perhaps atypical. This patient had normal blood coagulability on repeated tests so true hemophilia can be ruled out. This blood dyscrasia is also known as: Familial purpura hemorrhagica with-

out trombopenia, constitutional thrombopathy, athrombocytopenic purpura, hereditary pseudohemophilia and hereditary hemophilioid purpura. The fact that the medical personnel in the forward areas recognized this soldier as a bleeder was very helpful. Had he informed the military authorities of his bleeding tendency, at the time of induction, he would not have been accepted. The history in this case is of great interest to the surgeon in retrospect. The taking of a thorough history prior to surgery can not be overemphasized.

SUMMARY AND CONCLUSIONS

1. A case of a serious battle wound complicated by gas gangrene in an infantry soldier with hereditary hemorrhagic thrombasthenia is reported.

2. Failure of the soldier to give his known history at the time of induction nearly cost him his life.

3. The extreme efficiency of the army medical personnel in the forward echelons is well demonstrated in this case.

4. The true normal blood picture was difficult to obtain because of the numerous transfusions, but the bleeding time was constantly prolonged.

5. Sodium pentothal was a safe anesthetic in this case as it was administered on 16 different occasions between July 11, 1944, and Oct. 24, 1944, without toxic symptoms.

6. Massive doses of vitamin C seemed to stimulate healing in this case.

7. Gas gangrene developed despite the fact that sulfa drugs and penicillin were administered continuously.

8. This soldier survived gas gangrene, retroperitoneal hemorrhage, thigh amputations and disarticulation of the hip and several large vessel ligations. Anesthetics were administered 16 times and he went into shock on 10 different occasions. He also withstood 21 severe hemorrhages, received 59 blood transfusions (54 stored banked blood and 5 fresh), and a similar number of infusions of saline with glucose and plasma.

9. The fact that he returned to the U. S. in good condition is considered a medical and surgical victory.

10. The careful search for the existence of a hemorrhagic tendency prior to any contemplated surgical procedure can not be overemphasized.

BIBLIOGRAPHY

1. Fowler, W. M.: Hereditary Pseudo-Hemophilia. Am. J. M. Sc. 193: 191-198, February 1937.

2. Geiger, A. J., and Evans, A. G.: Atypical Hereditary Hemorrhagic Syndromes. Internat. Clin. 2: 135-157, June 1938.

3. Glanzmann, E.: Hereditäre Hamorrhägische Thrombasthenie, ein Beitrag zur Pathologie der Blutplattchen. Jahrb. f. Kinderh. 88, 1, 1918.

4. Lozner, E. L.: Hemorrhage and Hemorrhagic Diastheses. U. S. Navy Med. Bull. 40: 641-646, July 1942.

5. Cronkite, E. P., and Lozner, E. L.: Hereditary Hemorragic Thrombasthenia with Severe Post-Hemorrhoidectomy Hemorrhage. U. S. Navy M. Bull. 161-164, Vol. 42, No. 1, Jan. 1944.

6. Macfarlane, R. G.: Critical Review: the Mechanism of Haemostasis. Quart. J. Med. 10: 1-29, Jan., 1941.

7. Minot, G. R.: Familial Hemorrhagic Condition Associated with Prolongation of the Bleeding Time. Am. J. M. Sc. 175: 301-306, March, 1928.

8. Quick, A. J., The Hemorrhagic Diseases and the Physiology of Hemostasis. Charles C. Thomas, Springfield, Ill., 1942.

9. Rothman, P. E., and Nizon, N. K.: Familial Purpura Hemorrhagica without Thrombopenia, Hereditary Hemorrhagic Thrombasthenia. J.A.M.A. 93; 15-17, July 6, 1929.

10. von Willebrand, E. A., and Jürgens, R.: Über eine neue Bluterkrankheit, die konstitutionelle Thrombopathie. Klin. Wchnschr. 12: 414-417, March 18, 1933.

Psychosomatic Disorders

At the outset it must be realized that while psychoneurotics eventually develop organic disease, and eventually die, they are not peculiarly susceptible to organic disease. They frequently tire easily and are aware of minor disturbances of health, but the diagnosis is made on the basis of a personality study, and the somatic inventory may make it possible to add "without evident organic disease or dysfunction." The same is true in neurasthenia, hypochondriasis, hysteria with apparent dysfunctions, and so on. In such cases, psychosomatic practice is to ascertain that all real dysfunctions and all possibilities of benefiting the patient by treating the soma have been explored and not omitted as useless in view of the obvious disturbance of personality.

On the other hand, in the presence of conditions like mitral stenosis, chronic leukemia, or other organic disorder, the stresses imposed on the patient by the disease, by his past experiences and present environment must also be explored so that no opportunity to lessen his discomfort and improve his effectiveness is lost. Whether narcosynthesis, analysis, reports on the family and the job by social workers, or other aids to an understanding of the patient are invoked will depend on the type of case and the available skilled assistance.

In a very large proportion of outspoken psychoneuroses, as well as in cases of organic disease with the usual personality problems, an alert and experienced physician can effect just as good results with a minimum of effort, as could be obtained by the most prolonged psychoanalytic or other specialized study and management. In some cases errors of the experts may be disastrous but in a certain group failure of the usual management can be changed to a better result by the use of special technic for study of the psyche.

Psychosomatic studies have brought out the high frequency of certain types of personal history and emotional stress in specific organic diseases. In many cases it has not been proved that these correlations represent cause and effect, but merely the tendencies to develop specific disorders go along with the constitutions which predispose to certain patterns of behavior.—William Dock, M.D., Brooklyn, N.Y.; Texas State Jr. Med., Vol. XLI, No. 8, Dec., 1945.

Air Embolism Following Uterotubal Insufflation Report of Two Cases*

ROBERT L. FAULKNER, M.D.

TRANSUTERINE tubal insufflation is a diagnostic examination frequently performed not only by specialists in obstetrics and gynecology but by other physicians as well. That is as it should be, because properly done it is a simple, valuable, and safe diagnostic aid. However, there is a feeling that dangerous departures from the proper technique of uterotubal insufflation have crept into medical practice. The most serious of these is the use of air as an insufflation medium instead of oxygen or preferably carbon dioxide as stipulated by Rubin.[1,2] In other words, there has developed a great difference between uterotubal insufflation as practiced and the Rubin test. It seems desirable to report two deaths from air embolism which resulted from air technique.

The Author

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REPORT OF CASES

Case I. A colored woman aged 40, who had been unable to become pregnant since a miscarriage at four months, eight years before admission, came into the hospital for removal of an urethral caruncle and investigation of her sterility. Pelvic examination was normal except for the presence of the caruncle and three or four small myomas in the uterus. The patient was five days past the menstrual flow. Under nitrous oxide, oxygen ind ether anesthesia the vervical cannula was inserted after no manipulation other than the insertion of a uterine sound which showed the uterine cavity to measure 8½ cms. in length. Air was introduced into the uterine cavity by means of a rubber bulb manometer apparatus and seemed to flow through the fallopian tubes at a pressure under 100 mm. of mercury. With the machine used the amount of air introduced could not be measured. Curettment was then performed. A few moments later during removal of the urethral caruncle, the patient died.

At autopsy, the right auricle of the heart after proper exposure was punctured under water and a fairly large amount of air and frothy blood escaped from the puncture wound. It was not possible to measure the exact amount. There was no myocardial disease. The fallopian tubes were both closed and contained small amounts of air and bloody fluid.

Case II. A white housewife aged 30 was admitted to the hospital for study of sterility of two years duration. There had never been a pregnancy. Pelvic examination was normal. The day of the menstrual cycle was not recorded. Under nitrous oxide and oxygen anesthesia the cervix was dilated up to 12 mm. The cervical cannula was then inserted and an unmeasured amount of air introduced into the uterus by means of a rubber bulb manometer outfit. Manometer pressure never went above 100 mm. of mercury and it was assumed air flowed through the fallopian tubes.

A few moments later, during the insertion of a stem pessary, the patient apparently died. In addition to all ordinary efforts at resuscitation, the heart was exposed by surgical incision within 15 minutes of the collapse, and direct measures of restoration employed. An ankle vein cut down upon for administration of blood plasma contained air bubbles. It is not recorded that the operator felt air in the right auricle. The patient rallied for a few hours. Later exploration of the chest wound showed hemorrhage into the left pleural cavity. Death finally occurred nine hours after tubal insufflation.

At autopsy 11 hours after the introduction of air into the uterus no gas was discvovered in the abdomen or right auricle. Hemorrhage into the left pleural cavity estimated at 250 cc. was present. Focal necrosis of the myocardium was thought possibly to have contributed to circulatory collapse. Both fallopian tubes were patent.

DISCUSSION

These experiences make it obvious that air may be introduced into peripheral veins through an accidental and unintentional break in the mucosa of the uterine cervix or cavity. The rich venous bead of the uterine wall is too well known to demand description here.[3]

No doubt it is true that the amount of air introduced into the venous system in the human has to be large to cause death, but without a siphon flow meter on most air machines the amount introduced can not be measured. Data on air embolism in animals may be found in publications of Moore and Braselton.[4,5]

Whether the accident of air embolism following uterotubal insufflation can occur to a patient awake is not certain, principally because of the necessity for gentleness in performing the test and the use of a lesser amount of air. It is, however, scarcely the point when complete avoid-

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ance of the risk is possible. The use of air, even if it were not dangerous, has led too many women to fear the test because of pain attendant upon slow absorption of this medium.

Report of these accidents from improperly performed uterotubal insufflation does not mean to encourage the well-intentioned to turn enthusiastically to uterosalpingography with opaque media as a routine practice. It is believed the ideal totally harmless opaque medium has not yet been introduced.

Any uterotubal insufflation worthy of the name of Rubin test is a steady well regulated and measured flow of carbon dioxide gas. As such it is a clean, safe, and informative diagnostic test with reasonable therapeutic value.

BIBLIOGRAPHY

1. Rubin, I. C.: The Nonoperative Determination of Patency of the Fallopian Tubes by Means of Intra-uterine Insufflation. J.A.M.A. 75; pp. 661-666, Sept. 4, 1920.
2. Ibid: The New and Improved Apparatus for Uterotubal Insufflation, J.A.M.A., 92: 1597-1598, May 11, 1929.
3. Faulkner, R. L.: An Injection Study of Uterine Blood Vessels, Amer. Jour. Obsts. and Gyn. 49: January, 1945.
4. Moore, R. M. and Braselton, C. W.: Injections of Air and of Carbon Dioxide Into a Pulmonary Vein, Annals of Surgery, 112: pp. 212-218, Aug., 1940.
5. Ibid: An Experimental Study of the Embolic Effects of Air and Carbon Dioxide, The Southern Surgeon, 9: pp. 733-737, Oct., 1940.

Rheumatoid Arthritis

Thirty-four patients with rheumatoid arthritis, comprising 27 females and 7 males, were treated with a streptococcus-staphylococcus combined antigen (streptococcus toxin-bacterial suspension combined with staphylococcus toxoid-bacterial suspension). This therapy was used in combination with other therapeutic measures, such as, rest, diet, and supplemental therapy when indicated. Each patient was given individual attention; physical examination made; X-rays and laboratory reports obtained; and the condition and prognosis thoroughly discussed.

The clinical results obtained are gratifying and indicate that a further study of the value of streptococcus-staphylococcus combined antigen as a therapeutic agent in rheumatoid arthritis is warranted. Of the 34 patients treated, 47.06 per cent were able to resume normal activity; 29.41 per cent showed improvement in that their pains were controlled, swellings reduced, and were able to resume limited activities; 23.5 per cent showed only moderate improvement or none at all.—P. J. Warter, M.D., Trenton, N.J., D. A. Donio, M.D., Allentown, Pa., and S. Horoschak, B.S., Ridley Park, Pa.; Jr. Med. Soc. N.J., Vol. 42, No. 12, Dec., 1945.

Deaths From Hernia

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During the past few years the apparent increase in the number of fatalities following operations for the cure of hernia has inspired a survey of the claims filed during the year 1944. Statistics based upon claims filed show that during that year 5,157 claims were filed alleging hernias as a result of industrial injuries. The time loss from these claims totaled 413,246 days.

Unfortunately, our statistics are so compiled that there is no way of determining how many of these claimants were operated. It is found, however, that during the year 32 applications were filed for death claims following hernia operations. These deaths claims accounted for 192,000 days lost. Subtracting this number from the total days lost, an average disability of 43 days per claim was found. Counting the death claims with the total number of days lost, this average per claim is 30 days. It is found therefore that the fatalities resulting from hernia operations are nearly double the time lost from injuries resulting in hernias.

In making the survey of the death claims 30 out of the 32 files were available. It was found that the decedents were all males from 22 to 80 years of age with 21 between the ages of 50 and 70. The reports on file indicate that 14 of the deaths were due to pulmonary embolism; 8 to conditions complicating strangulation of the hernia; 3 to coronary occlusion; 1 to pneumonia, and 4 to miscellaneous causes. In most instances death occurred before the decedent left the hospital. Twenty-four occurred before the twentieth day.

Hernia operations are usually considered quite safe, especially those in which there is no evidence of strangulation. The above information, however, shows that sudden and unexpected death can result from a blood clot in the circulation resulting in the occlusion of an artery in the heart or in the lungs. Such an occurrence is not the result of any negligence on the part of the surgeon, nor can it be predicted or avoided by physical examination prior to, or at the time of operation. Just why it should occur in some cases and not in others is probably unknown.

The presence of hernia can usually be detected in pre-employment examinations and when found it should be given attention in order that the employee can be given suitable work at which there is but little opportunity for sprains or strains. Proper attention to the correct manner of lifting is also of importance in avoiding hernia and back strain.—Ohio Industrial Commission Monitor.

Notes on Heart Failure

DAVID L. BEERS, M.D.

IN the recent literature, I have read instances of unfavorable reactions in the use of salyrgan which may be a deterring factor to some for its administration. I have received this information from informal conversations with numerous practitioners, some of whom have had what thy considered unfortunate experiences themselves, but the majority based their opinion on the reports of others.

The Author

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SALYGRAN

In my personal experience, I have had no bad general reaction from any salyrgan injection so I wish to defend what I believe to be a very valuable drug. In the past 12 months I have given 670 intravenous of 2 cc. each of salyrgan to 45 individuals which represents a fair average of its use over the past few years. The intramuscular route is preferred by many over the intravenous method in defense of which it is claimed to be safer. My experience, as stated above, does not confirm this and there is no likelihood of pain at the site of the injection if given properly by vein. Very rarely, a slough may occur at the site of the venipuncture if the material extravasates into the adjacent tissue. In the past 15 years, I have had that happen twice. In both instances the edema had involved the upper extremities as well as the lower. I have always injected it as rapidly as possible. Ammonium chloride has been recommended as adjunctive therapy, but I have been unable to detect any difference in the response to the salyrgan in those getting it and those who did not. Consequently, I abandoned the ammonium chloride some years ago under the assumption that proper electrolyte balance could be maintained without it.

Diuresis usually takes place in about an hour and the effect of one injection persists for the next four or five hours. Therefore, the morning is the most convenient time for the patient as there is then no chance for the increased urinary output to disturb rest at night. The injections may be given in the office, but the patient should be reminded of the time it will take effect to save possible embarrassment.

INDICATIONS

The classical indication, of course, is congestive heart failure with peripheral edema and ascites. Hydrothorax from failure of the circulation is somehow influenced but little by salyrgan and should be mechanically removed. Paracentesis abdominis, however, is rarely necessary and if the quantity of fluid is small, it dsappears more rapidly if the patient is allowed to be ambulatory.

Of course, bed rest is sometimes essential in heart failure, but I think prolonged periods of inactivity have been overdone especially in the degenerative types of lesions and in my experience they do better if allowed to stir around most of the day, if they are at all able to do so. Edema is present to the greatest degree in the dependent portions of the body so I think stressing one particular position just redistributes it rather than eliminates it. The symptom, orthopnea, would seem to indicate that the recumbent position creates greater strain than does activity compatible with the general picture. In the final analysis, the fundamental goal being striven for is comfort.

Since salyrgan contains a heavy metal, naturally there arises the possibility of contraindications in regard to further kidney damage. Evidence of renal insufficiency is a usual accompaniment of congestive failure and an N.P.N. of 75 mgs. per cent is a not unusual finding. Likewise, red blood cells often appear in the urine as merely the result of passive congestion. In such an eventuality, I have hesitated to give it, but in the instances where I thought the benefits outweighed the possible dangers, the results have been uniformly gratifying so I no longer am very much influenced by the urinary findings and blood chemistry if I feel certain that the drug will be of benefit.

EDEMA

The particular type of heart disease responsible for the failure is not a criterion for its use as the degenerative and rheumatic groups respond about equally. Once the edema is controlled, the frequency of the injections may be decreased according to the results obtained, and an inflexible routine need not be established since an intelligent patient soon learns the most optimum intervals. Careful observation of the body weight will often be an index of the situation because an otherwise unexplained gain of a few pounds will herald the advent of edema.

Submitted October 29, 1945.

Salyrgan's use is not necessarily confined to congestive heart failure as it is sometimes helpful in cases of paroxysmal dyspnea. I have tried it in numerous cases of so-called cardiac asthma in which one or two injections a week have improved the response to exertion and greatly reduced the incidence of nocturnal dyspnea even though pretibial edema has at no time been demonstrable. These seizures of shortness of breath are of course representative of serious heart disease and emergency measures have to occasionally be superimposed on the general management of the case. Since the breathing is of an asthmatic type, there is a temptation to give adrenalin, but here it has no effect. Morphine produces dramatic results and should be given in an adequate amount the first dose. One-fourth grain rarely is sufficient and has to be repeated whereas an initial dose of one-half grain will work in a few minutes with repetition unnecessary. Of course, there are exceptions and considerable judgment has to be exercised in patients of advanced age where it is safer to begin with the smaller amount. Here again, I believe bed rest has been overdone and I do not think an attack of paroxysmal nocturnal dyspnea should automatically mean weeks in bed.

I have tried it in cases of the angina syndrome alone but with no clinical improvement resulting as far as enlarging the comfortable sphere of activity is concerned. In addition to the nitrites for immediate relief, I think aminophyllin or similar preparation given intravenously two or three times a week proves of help but no drug therapy promises complete relief with unlimited activity. The oral administration of aminophyllin I have found disappointing because of uncomfortable digestive disturbances occurring when a sufficient dose is given to make an impression on the clinical picture.

FLUIDS

Restriction of fluid intake in congestive failure is a time-honored and traditional procedure, but I have fouond that it does nothing but add thirst to the symptoms already present. I have even come to the conclusion that a little more water than usually taken to satisfy the normal desire seems to actually help things along. I have also reached a similar conclusion in regard to dietary restrictions and allow the patient's natural selection to govern the choice of food because he is better aware of what disagrees with him than anyone else. At times, there are cravings for outlandish combinations under the circumstances which, if satisfied just once, will often start an individual to again eat a satisfactory well-balanced diet. One item of advice which is merely in the realm of common sense is frequent small meals rather than one big one during the day.

In regard to the use of drugs in general, digitalis of course has held first place for generations, but no drug had been abused as much by the average practitioner. It is given when not at all indicated and when definitely essential, the dose is often woefully inadequate. This especially holds true of the tincture because the ordinary medicine dropper delivers anywhere from 40 to 70 drops per cc. and will be prescribed in doses based on the theoretical 16 minums to the cc. If accurately measured, however, the results with the tincture compare favorably with those of the powdered leaf and if rapid digitalization is desired, a teaspoonful dose is a convenient method of taking four cat units.

It is generally agreed that the indication for digitalis is just one, i.e., congestive failure. I would alter this to be auricular fibrillation of a permanent nature not due to thyrotoxicosis. I appreciate that experimentally, its pharmacodynamics prove that it should reduce venous pressure in congestive failure regardless of the heart rhythm and I am aware that I am in the minority when I think that it does very little good in the presence of rhythm other than auricular fibrillation. It must be remembered that in most instances, the patient has been put to bed and other methods employed, and I think digitalis is given credit for results it does not deserve. In auricular fibrillation, the rate can be reduced to from 70 to 80 per minute in from four to six days with four cat units daily, and then be maintained at that level on about one cat unit daily. Most persons can soon govern their ration according to the radial pulse rate because when the precordial rate is 80 or below, the pulse deficit is negligible. Concerning the so-called small tonic dose, I do not believe there is any justification for its use. For the heart patient requiring bed rest, judicious use of morphine accomplishes the best results.

OTHER DRUGS

Other drugs advocated in congestive failure, especially for emergency use such as coramine, camphor in oil, cactin, etc., are of very little benefit, but at times I have though that caffein was of value particularly if there was an associated peripheral vascular failure.

The general management of the cardiac patient's routine is sometimes difficult because of variations from time to time of his limitations. In an effort not to exceed those, I tell him to find out what he can not do and then never do it again.

Accidents occurring in and about the American home claim around 32,000 lives a year and, of the victims, some 24,000 are adults. The greatest number of fatal injuries in home accidents, about one-fourth of the total, resulted from injuries suffered in the bedroom, and the proportion was the same for men as for women.

Early Ambulation in Abdomino-Pelvic Surgery

JOHN J. McDONOUGH, M.D.

THERE is a growing trend in surgical practice to encourage early ambulation following major operations. While the idea is not new, acceptance of it by the profession has been slow, with controversy among American surgeons since 1899 when Emil Ries[1] of Chicago first advocated it.

My interest in early postoperative rising was stimulated by Leithauser and Bergo[2] who in 1941 reported 383 appendectomies with average confinement to bed of 1.5 days and average hospital stay of 2.3 days. At that time I was a surgical resident, and it was our practice to keep all patients in bed 10 to 14 days following a major abdominal operation. The only break I could find in this traditional practice was in allowing postoperative appendectomy and herniorrhaphy patients to be up on the side of the bed or on to the floor to enable them to void. However, as soon as voluntary bladder control was established the patients were subsequently confined to bed for the usual 10 to 14 days.

Despite our trepidation when it was necessary to get such a patient out of bed, I noted no ill effects. The wounds healed well and, on questioning, the attending surgeons said that such measures did not apparently predispose to a weak scar. In private practice I have gradually applied the principles of early postoperative rising and the results have been gratifying.

In this paper I will discuss ambulatory surgical management and report my results on 304 cases. To review the whole literature would only repeat the work of Newberger[3] who in 1943 wrote an excellent collective review and gave 189 references in his bibliography. By far the majority of references are in the foreign literature.

André Chalier[4] in a lengthy paper spares no words to convince others of the efficacy of early rising after abdominal surgery. However, he is taken to task by his colleagues, Cotte[5] and Villard,[6] who report three cases of fatal emboli following the use of this method. Chalier replies that early postoperative rising may not prevent all embolic phenomena but that it definitely lowers the incidence. A statistical report on his own results bears this out.

For the most part the remaining available references enthusiastically endorse early postoperative rising and walking and encourage a more widespread usage.[7-22]

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REVIEW OF CASES

Throughout the literature there is a wide variance in defining early postoperative rising. In this report I shall include as "early risers" only those patients who were out of bed during the first postoperative 24 hours. Two series of cases are presented. In 1943 I was unable to get the patients out of bed consistently and rising occurred anywhere from the first to twelfth day. In 1944 the rule was more generally and accurately applied and in this latter series I omitted from study any patient who did not get up on the first postoperative day. There is a significant difference in the total hospital stay of the two series and I have presented both groups for that reason.

POSTOPERATIVE CARE

The patients on returning to their rooms are placed flat in bed, usually with one pillow, and allowed sips of water and liquids as desired. They are encouraged to change their position in bed freely and told that it is beneficial to move rather than to lie perfectly still. Moreover a normal amount of activity will promote the healing of their wound rather than break it down. A 5 per cent carbon dioxide and 95 per cent oxygen mixture is prescribed routinely and given for 10 minutes every hour for eight hours after surgery. The supervisor is instructed to use the carbon dioxide-oxygen mixture every four hours thereafter if necessary for shallow breathing. Deep breathing exercises are encouraged and the aged patient is watched closely in this regard. Morphine or pantopon is prescribed for pain and codeine is substituted as soon as possible.

The following morning, the first postoperative day, the abdomen is examined and carefully and firmly supported with a Scultetus binder. The patient is allowed to sit up on the side of the bed, instructed to hold the abdomen with both hands and cough, attempting to bring up any

COMPARATIVE SUMMARY OF OBSERVATIONS ON PATIENTS EXPERIENCING EARLY AND LATE POSTOPERATIVE RISING

	Number of Cases		Day of Rising		Day of Discharge	
	1943	1944	1943	1944	1943	1944
Total Hysterectomy (Abdominal)	34	40	..*	1.0	11.8	8.9
Subtotal Hysterectomy	5	0		..	12.1	..
Vaginal Hysterectomy	4	5		1.0	11.5	8.1
Myomectomy	2	6		1.0	13.0	8.6
Adnexal Resection	7	28		1.0	10.1	7.3
Uterine Suspension	5	16		1.0	10.0	6.5
Presacral Neurectomy	2	6		1.0	10.1	6.8
Watkin's Interposition	3	5		1.0	15.0	8.4
LeForte Colpoclysis	0	3		1.0	..	13.5
Vaginal Plastic	6	10		1.0	12.7	8.4
Bilateral Salpingostomy	0	1		1.0	..	7.0
Caesarean Section	2	5		1.0	14.0	9.0
Appendectomy	28	63		1.0	7.2	5.4
Cholecystectomy	3	7		1.0	14.5	8.0
Herniorrhaphy	1	5		1.0	12.0	8.6
Exploratory Laparotomy (Intestinal Obstruction)	2				13.0**	
Total Number of Cases	104	200				
Average Postoperative Stay in Hospital					11.9	7.9

*Day of rising first to twelfth day.
**One patient expired.

mucus in the throat or bronchi. She is then allowed to stand on the floor and the procedure is repeated. In the afternoon the same routine is followed. At this time, however, she is requested to take two or three steps to the bedside chair and is allowed to remain up 10 minutes or more as desired.

This routine is carried out each postoperative day, increasing the time and span of walking and remaining out of bed. The skin clamps or sutures are removed on the fifth or sixth postoperative day and longitudinal abdominal incisions are reinforced using two wide adhesive bridges. Transverse incisions are not reinforced. At the present writing, almost all elective major abdominopelvic surgical cases are discharged home on their fifth or sixth postoperative day. All patients are requested to report to the office for follow-up care one week after discharge from the hospital.

ADVANTAGES OF EARLY AMBULATION

The advantages of early ambulation are many. Specifically, pulmonary ventilation is much improved if the patient can be placed upright following operation. Consequently, pulmonary atelectasis and collapse with its train of complications is reduced.

Leithauser[23] has shown that after abdominal surgery with early rising the vital capacity of the lungs approaches normal in approximately one-half the time that it does if the patient remains recumbent. The greatest reduction in the vital capacity occurs in the immediate postoperative period. Consequently, most pulmonary complications develop in the first 24 hours and in any event by the end of the third day. Deep breathing and coughing exercises and getting out of bed in the first 24 hours offer the greatest prophylactic and therapeutic value in the management of pulmonary complications.

Most men writing on early ambulation have the impression that the incidence of thrombosis and embolism is reduced by early rising and walking. Nevertheless, there is no absolute proof of this. It does seem logical to suppose, however that thrombosis of the superficial and deep veins of the extremities is less likely if rising and walking begin early.

In two of the cases presented, moderately severe superficial thrombo-phlebitis developed postoperatively. Yet, ambulation was continued and recovery was complete. Treatment included codeine for pain, the application of elasto-plastic bandage and ice. Both of these patients had previously had recurrent pain, swelling, and discoloration of these varicosities and did not appear too concerned when the condition arose following their operations. My first inclination was to keep these patients in bed with rest and elevation of the extremity. However, I could detect no involvement of the deep venous circulation so ambulatory treatment was continued and improvement was rapid and complete.

It would be false to declare that early ambulation will of itself prevent embolic phenomena. However, I do believe that it should take its place in the prevention of phlebothrombosis along with careful handling of tissues, elimination of mass ligation, careful hemostasis and antisepsis.

There seems to be little disagreement regarding the benefits to the bowel and bladder fol-

lowing early ambulation. Voiding is early and spontaneous in most instances. A return to normal bowel action is usually rapid and the use of enemas and cathartics can be greatly reduced. Going to the bathroom the first or second postoperative day is not only a boon to the nursing staff but it is a real satisfaction to the patient despite the moderate amount of associated pain. Before getting my patients out of bed early I was constantly using one cathartic after another in an effort to find one that would keep the patient's bowel activity normal for 10 to 14 days. I never found the ideal cathartic, but with the use of early rising I prescribe laxatives infrequently. Aside from one or more enemas on the second or third postoperative day the patient's normal activity appears to eliminate the use of purgatives.

It is almost needless to remark that the early ambulatory patient has much better morale than one confined to bed for a long time. Though most patients suspect at first that getting up within 24 hours after a major operation is absolutely wrong, they are quick to fall in line with the idea and are surprised to realize that they can sit up and walk about without too much pain. After the third and fourth day they are extremely proud of their progress and have gained a self-confidence that promotes a rapid convalescence.

Economically, early rising offers a tremendous saving to both patient and hospital. It should reduce the average hospital stay to approximately one-half. For example, the average appendectomy patient probably need not remain in the hospital more than five days and the average laparotomy case not more than seven days. Hospital records prior to early ambulation reveal that the average stay following the uncomplicated laparotomy was 10 to 14 days. The economic saving is obvious. As to nursing care, there is a marked simplification. Allowing the patient out of bed eliminates many nursing duties previously required. First, the patients are able to take care of many of their own personal necessities. Second, they are not subjected to a long recumbency in which many additional nursing procedures would be required.

Kimbarovskiy[24] and Newburger[25] conclude that early postoperative rising helps the healing of wounds. Specifically, activity appears to improve the circulation of the entire body. Moreover, this improvement occurs in the wound area and accelerates the healing rate. There is a prompt resolution of the fibrin mass at the wound margins and rapid organization of connective tissue to form a satisfactory strong wound. Kimbarovskiy, studying the microscopic wound sections, taken at intervals throughout the postoperative period, has shown that immobilization of dogs following standard laparotomy wounds revealed a sluggish resolution of fibrin and a slow organization of connective tissue.

In general, normal and satisfactory wound healing occurs when the patient is gotten up early. Clinically the gross appearance of the wound is the same as when the patient is recumbent. However, in my experience the wounds of early risers are as strong or stronger than those kept recumbent in bed. The objection that early rising may place too great a strain on the wound is illogical because the greatest tensile strength of suture material, especially catgut, is during the first days postoperatively and weakest from probably the tenth to fourteenth day.

THE DISADVANTAGES AND CONTRA-INDICATIONS

The only serious disadvantage that I have noted following the early rising routine has been the moderate discomfort and pain noted by the patient when she is moved about freely during the first and second days following her operation. However, if the advantages can be adequately explained to the patient this objection can be overcome in most instances. Nevertheless, some patients will positively refuse to get out of bed the first day following their operation and no amount of coercion will make them do it. I do not insist that these patients get up because I believe it would be wrong psychologically and, moreover, if for some reason beyond ordinary control the patient should develop a serious complication or even die, the procedure of getting the patient up might be held responsible, especially if early rising is not fully accepted in the community.

I think it is unnecessary to list contra-indications to early postoperative rising. The decision should be left to the surgeon's judgment. Any patient too sick medically or surgically to get out of bed should not be allowed to rise. A patient seriously ill with an elevated temperature, severely toxic, or greatly weakened through blood loss or for some other reason is obviously in no condition to walk about a room whether she has had surgery performed or not. However, in most elective major operations in which the operation has been carefully carried out and the patient's general condition is satisfactory, early ambulation can be followed. I do not believe that a drain is a contra-indication. In approximately half of the cholecystectomies presented I have inserted a drain and these patients were up on the first postoperative day and their wounds healed normally.

Moreover, a vaginal plastic repair or the presence of a catheter need not confine the patient to bed. I have eliminated the use of catheters as much as possible, preferring to catheterize

the patient every eight hours until bladder control is established and thereafter allow her to void spontaneously. The only exception follows the repair of a vesico-vaginal fistula when it has been my practice to use the indwelling catheter and keep the patient prone on a Bradford frame for 14 days. However, if a catheter is used it may be temporarily clamped off while the patient is up and about.

Following major or minor vaginal surgery, allowing the patients up does not appear to place too great a strain on the suture lines, and the patients are, if anything, more comfortable than the patient with an abdominal wound. Moreover, healing of the vagina and perineum is normal.

SURGICAL TECHNIQUE

Ninety-five per cent of the above analyzed cases were operated upon under spinal anesthesia. Both absorbable and non-absorbable[26] suture material has been used and I have been unable to note any superiority of one over the other. Using black silk I have had to remove one or more silk sutures from the wound to enable it finally to heal. I have not observed this in the use of catgut. However, with catgut I have noted in some instances a so-called wet wound from which serum would exude for a few days. However, there was no sinus formation and in almost all instances the wound was completely dry and healed two weeks postoperatively. On the other hand, I removed silk suture from one patient six months postoperatively. The wound had healed well except for one small sinus and on removing the black silk suture complete healing followed.

I use an interrupted suture technique throughout except to approximate peritoneal surfaces. I do believe that a continuous running suture in the fascia is unwise because the entire integrity of the abdominal wound is placed on the security of one knot. If for any reason it should become loosened the entire fascial support would be weakened and an evisceration could occur. Chromic catgut as fine as possible has been used and, at the present time, chromic 0 is used in the fascia, chromic 00 and plain 00 for ties, and chromic 0 for pedicle ligation. Retention sutures have not been used in any case.

Alloy steel wire has been used as indicated. I have employed fine alloy steel wire in two patients with bronchiectasis, both of whom had previous operations with dehiscence of their wounds. The healing in this instance was rapid and normal although both patients coughed continuously. I have likewise used wire where a previous incision has left a weak scar and a large defect caused by a drain. I have also used wire in old patients with obese abdomens and weak fascial support. The more I use fine alloy steel wire, the better I like it. It appears to cause very little tissue reaction and is not affected by the presence of infection. The only culty of suturing with wire. This technique can be learned and is no discredit to steel wire.

I have eliminated the use of drains as much as possible. Following cholecystectomy one Penrose drain is inserted if complete approximation of the peritoneal surfaces is not accomplished or if there is any question of the leakage of bile. I do not drain the pelvis abdominally or vaginally. I do not believe that it is possible to adequately drain the lower abdomen or pelvis using the ordinary Penrose drain except perhaps through the cul-de-sac. I have had no experience with so-called "sump" drainage. This, however, does seem a much more logical approach to the problem of drainage.

DISCUSSION

During the preparation of this paper I myself developed and had removed an acute, diffuse, inflammatory appendix. This allowed me a direct, personal experience with early postoperative rising. The operation, a McBurney appendectomy, was performed in mid-afternoon and I was allowed out of bed the following morning. Thereafter I had bathroom privileges and took my meals in the bedside chair or upright in bed. Two injections of pantopon, grains one-third, and two injections of codeine, grains one, were used for pain during the first 36 hours. An enema was prescribed for me on the second and third postoperative days for the relief of gas pains. Otherwise, my postoperative course was uneventful. The clips were removed and I was discharged home on the fifth postoperative day.

Getting out of bed the first and second day after operation was undeniably painful but was not, I feel assured, beyond the pain threshold of the average patient. I noticed specifically that if my anterior abdominal wall was tightly bound, using a Scultetus binder, and the incisional area reinforced, the feeling of pain was markedly reduced. While the pain decreased daily, the feeling of weakness and strain in the incisional area remained for 21 days. Thereafter, with or without abdominal support the abdominal wall felt the same. It occurred to me that if a Scultetus type binder could be made incorporating a fabric that contained rubber, excellent support would be assured and getting patients out of bed would be less painful and more cooperation would be obtained. I have improvised and put in use a binder made of elastic material. If it should prove useful I shall report its construction later.

I am convinced that if an incision is surgically sound, and the patient need not be confined to bed for special surgical and medical reasons, it is possible to get her up the first postoperative day and walking in moderate comfort if the abdominal wall is adequately sup-

ported. Getting patients out of bed the first postoperative day is confusing to many of them because the feeling of pain, weakness and strain in the incisional area does not seem logical and they fear that rupture of their incision and postoperative herniation are certain to result. If this can be modified and somewhat relieved, the patient will be more active and cooperative.

CONCLUSION

1. In 200 abdomino-pelvic, surgical cases all patients were allowed out of bed on their first postoperative day.

2. The procedure is safe; it promotes a rapid uneventful convalescence and reduces complications.

3. Economically, less nursing care is required and the hospital stay is shortened.

4. Personal experience convinced me that early ambulation, although moderately painful, is not beyond the pain threshold of the average patient. Moreover, this pain can be markedly reduced if the incisional area and the abdominal wall are adequately supported. A snug fitting Scultetus type of binder constructed with a fabric that contains a small percentage of rubber appears to offer excellent support.

BIBLIOGRAPHY

1. Ries, Emil: Some Radical Changes in After-Treatment of Celiotomy Cases. J.A.M.A., 33:454-456, Aug. 19, 1899.

2. Leithauser, D. J., and Bergo, Howard L.: Early Rising and Ambulatory Activity After Operation: A Means of Preventing Complications. Arch. Surg., 42:1086-1093, June, 1941.

3. Newburger, Bernhard: Early Postoperative Walking. II. Collective Review. Surgery, 14:142-154, July, 1943.

4. Chalier, A.: Early Rising After Operations. Lyon Chir., 31:261-289, May-June, 1943.

5. Cotte, G.: Fatal Embolism On Eighth Day Following Early Rising After Operation. Lyon Chir., 36:441-445, July-Aug., 1939.

6. Villard: Two Cases of Fatal Embolism During the Course of Early Postoperative Rising. Lyon Chir., 30:606-608, Sept.-Oct., 1933.

7. Charbonnier, A.: Early Rising in Laparotomy Patients. Helvet. Med. Acta, 9:166-182, March, 1942.

8. Daumerie, L.: Conditions of Early Rising After Operation and Question of Preventing Postoperative Complications. Bruxelles-Med., 18:534-547, Feb. 20, 1938.

9. Ducuing, J., and Guilhem, P.: Necessity of Early Postoperative Rising and Exercise in Treatment of Obstetrical and Surgical Phlebitis. J. Med. Franc., 23:74-76, Feb., 1934.

10. Pepe, C. J.: Advantages of Early Postoperative Rising After Laparotomy. Rev. Asoc. Med. Argent., 47:2846-2852, July, 1933.

11. Reynberg, G. A.: In Defense of Early Rising After Operations. Novy Khir. Arkhiv., 34:99-110, 1935.

12. Zava, L.: Advantages of Early Rising After Operation. Policlinico (Sez. Prat.), 47:865-872, May 20, 1940.

13. Ricard: Embolism in Relation to Early Rising After Surgical Interventions. Lyon Chir., 36:448-450, July-Aug., 1939.

14. Ricci, G.: Immediate Postoperative Rising. An. de Cir., 2:175-207, Aug., 1936: Abstr., Bol. y Trab. de la Soc. de Cir. de Buenos Aires, 20:268-279, May 27, 1936.

15. Wichmann, S. E.: The Significance of "Early Rising" in the Prophylaxis of Thrombosis and Embolism. Acta Soc. Med. Fennicae Duodecim, 1939, 27: Fasc. 1-2; Abs.: Internat. Abstr. Surg., 70:297-298, March, 1940.

16. Rioux, J. E.: Early Postoperative Rising. Union Med. du Canada, 72:386-391, April, 1943.

17. Harild, S.: Question of Advisability of Early Rising After Laparotomies. Chirug, 12:703-707, Dec. 1, 1940.

18. Khromov, B. M.: Value of Early Rising Postoperatively to Prevent Pulmonary Complications. Sovet. Khir., No. 9, Pp. 389-397, 1936.

19. Kimbarovskiy, M. A.: Effect of Early Postoperative Rising on Healing of Wounds: Experimental Study. Novy Khir. Arkhiv., 48:116-121, Nos. 189-190, 1940.

20. dell'Oro, B.: Early Postoperative Rising. Rev. Asoc. Med. Argent., 56:163-164, March 15-30, 1942.

21. dell'Oro, B.: Early Postoperative Rising: Ten Years' Results. Bol. Soc. de Cir. de Rosario, 10:124-130, May, 1943.

22. Smith, P.: Early Rising in Abdominopelvic Surgery: Study Based on 900 Cases. Union Med. du Canada, 69:921-942, Sept., 1940.

23. Leithauser, D. J.: Confinement to Bed for Only Twenty-four Hours After Operation: A Means of Preventing Pulmonary and Circulatory Complications and of Shortening the Period of Convalescence. Arch. Surg., 47:203-215, Aug., 1943.

24. Kimbarovskiy, M. A.: Effect of Early Postoperative Rising on Healing of Wounds: Experimental Study. Novy Khir. Arkhiv., 48:116-121, Nos. 189-190, 1940.

25. Newburger, Bernhard: Early Postoperative Walking: I. The Influence of Exercise on Wound Healing in Rats. Surg., St. Louis, 13:692-695, May.

26. Nelson, E. W., and Collins, Conrad, G.: Cotton Suture Material and Early Ambulation in Gynecology and Obstetrics. Surg., 12:109-114, July, 1942.

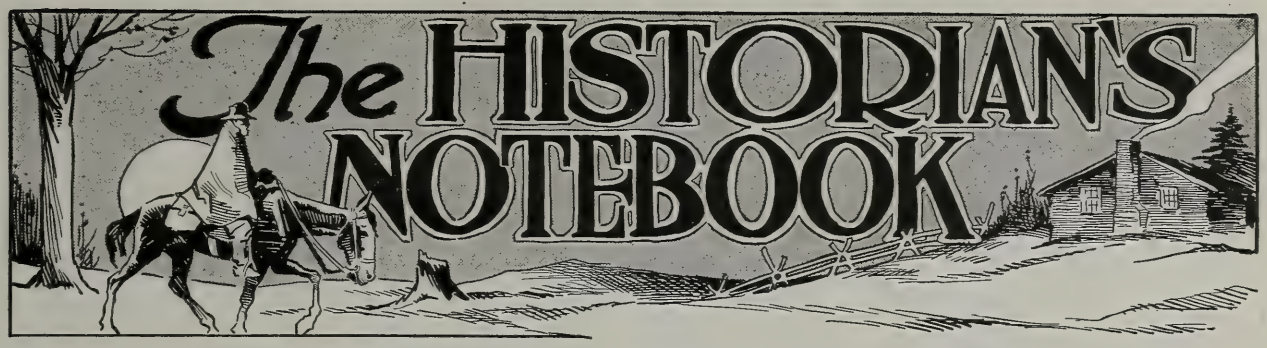
Hypertension

When the etiology of a disease is obscure, treatments are many. It is not surprising, then, that suggestions for the treatment of hypertension come thick and fast. Kempner advises a diet composed of rice, sugar, fruit, iron and vitamins, with severe restriction of salt, fats, and animal proteins. Grollman and Harrison revert to the old idea of drastic salt restriction. Some observers advise reliance upon sulfocyanates, while others emphasize the predominance of heredity and the neurogenic element in the hypertensive syndrome. Surgery of the sympathetic nervous system has a definite but uncertain value. The removal of the chromaffin tumors of the adrenal frequently produces a dramatic cure in paroxysmal hypertension.

It is probable that all of these suggestions are useful in selected cases, for hypertension is not a disease, but a symptom of diverse underlying pathology. It is irrational to supply the same therapy to all patients with a syndrome produced by different etiological factors, many of which are themselves uncertain and unproved.

The hypertensive pot is boiling, and this state of activity is highly desirable in the study of a syndrome which occupies the unenviable distinction of being one of the great killers of mankind.

Perhaps the safest course for the practitioner to follow is to adopt an eclectic attitude and individualize his cases, so far as modern means permit, remembering that sauce for the goose may not be sauce for the gander.—Editorial; N.C. Med. Jr., Vol. 6, No. 12, Dec., 1945.



Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio

The Vaulting Imagination of John L. Riddell*

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Whatever makes the past or future predominate over the present exalts us in the scale of thinking beings.—Johnson.

THE name of John Leonard Riddell is, perhaps, best remembered today for his *Synopsis of the Western Plants.* In 1835, when this was published, Cincinnati was the western-most city of great size, with around 35,000 inhabitants, and with immediate, perhaps daily, expansion in commerce and culture. In 1830, Cincinnati had less than 25,000 while Columbus, the second in size, had 3,400. The West, spelled with a capital, meant almost unlimited opportunities for hardy souls from the Atlantic States, who, crossing the mountains from Virginia, New England and Pennsylvania, all converged in the Ohio Valley.

Riddell's *Synopsis of the Western Plants* is the most important catalog of plants written by a resident botanist west of the Appalachians of that period. It antedates by three years the first volume of the *Flora of North America,* on which Drs. John Torrey and Asa Gray were laboring. Dr. Daniel Drake, in 1815, in his *Picture of Cincinnati* devotes a brief section to botany. So it is probable that Drake himself, during Riddell's connection with the Cincinnati College, harried Riddell into the publication of his somewhat regional summary. In a paragraph signed by "The Editor" in the July, 1834, number of the *Western Journal of the Medical and Physical Sciences,* Drake introduces the article "Particular Directions for Collecting and Preserving Specimens of Plants," by Riddell, as follows:

We hope he will append to his practical directions a catalog of such plants of the State of Ohio as may have fallen under his observation. He is, we feel assured, a sound practical botanist, who may, perhaps, do for Ohio, sooner or later what Professor Short is zealously laboring to effect for Kentucky. By the way, why does not the Professor bring out the Flora for which he must have on hand such ample materials? Its publication would do more to promote the study of Botany in the basin of the greatest of Rivers than a thousand of our paragraphs.

If it was Drake as an editor who kept after Riddell to prepare the flora, credit must also be be given to Dr. Samuel P. Hildreth of Marietta. Riddell had visited Hildreth before going to Worthington, and Hildreth had compared him to Robert Peter of Lexington, and urged him to exchange specimens with Charles W. Short, John Eberle of Cincinnati, and others. Riddell's introduction to the *Synopsis* not only remarks that it had been his design for several years to publish a flora of the western states, but contains a list of "the scientific gentlemen residing in the West to whom the student in botany can refer with advantage." He does not include Dr. Torrey as a profitable correspondent since he often was a whole year late in answering letters. On September 3, 1834, Torrey had, however, answered a letter of Riddell's written May 29, of the same year.

EARLIEST FLORA BY A RESIDENT

It was, therefore, extremely interesting to find that Riddell had published the first of our

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now numerous county floras in Ohio. It antedates by a year the *Synopsis* and since he was at that time teaching at the Worthington Medical College it was Franklin County on which he published. How had this modest little flora escaped attention? The answer is that Sullivant's catalog of the plants of Columbus and vicinity published as a book in February, 1840, was larger and much more useful as well as more available. No mention of the work of Riddell is made by Sullivant, probably because the departure of Riddell was followed by an increasingly unsavory docket of rumors concerning the Worthington Medical School. The socially prominent Sullivant would not notice anyone connected with it. But for two reasons Sullivant could not have been unaware of the school's existence even if he chose to ignore it. His father, Lucas Sullivant, had been a trustee of the Worthington Academy, the forerunner of the college, and J. R. Paddock who succeeded Riddell in the teaching of botany in the college, was mentioned in Sullivant's preface. He also was reputedly a good friend of Sullivant's.

Riddell's catalog[1] follows the nomenclature he had learned from a brief course with that greatest teacher of natural sciences, Amos Eaton, who was courageous enough to break away from the Linnæan system of classification and adopt Lindley's natural system. Riddell adds a number of abbreviations, fifteen in all, to indicate the particular situations in which he collected the specimens. He later followed the same system in the *Synopsis of the Western Plants* and added other symbols. The Franklin County list thus makes a more than respectable account of some 750 items. It furnishes also something of a clue to the distribution of the plants in the situations in which these grow.

CORRESPONDENCE WITH DR. JOHN TORREY

Apparently Riddell kept no specimens or if he did it was only to sell them when an opportunity came. At that time he was ready to sell anything negotiable. The postage on letters was to him an expensive item. In passing it might be remarked that he traveled farther than he knew south of Franklin County or that some plants he saw no longer exist in the county. He mentions *Kalmia,* the mountain laurel, and the red variety of flowering dogwood. Both of these are to be seen in Fairfield County at the present time about fifty miles from Worthington. A preliminary alphabetical list which he forwarded to Torrey, now in the New York Botanical Garden bears little relation to the Franklin County flora.

It need not be implied that Sullivant's failure to note Riddell's catalog was an intentional rebuff since the medical journal was probably not available to him and he was under no obligation to credit some work he had never seen. Paddock, although formerly Riddell's colleague, was probably not in correspondence with him after Riddell had resigned to go to Cincinnati. Sullivant probably was familiar with the *Synopsis of the Flora of the Western States.*[2] At least it could have been obtained and Paddock's name was included in the list of "scientific gentlemen" in the preface Riddell had given to his work. The letter written by Sullivant to Dr. Torrey[3] in 1838, however, does not list it among the botanical books in his possession. It is just barely possible that Sullivant had not heard of Riddell. Certainly, during his entire time in Ohio there were things happening to Riddell that he would himself like to forget, but which he confided only for his own perusal, to a personal journal.

RIDDELL'S PERSONAL JOURNAL

This journal which is now a part of the rare book collection of the Howard-Tilton Memorial Library of Tulane University consists of twenty-eight holograph volumes. It is alternately inscribed by Riddell as "Repository"[4] or "Personal Journal." Never is it referred to simply as a diary. It covers the portion of his life from the time he left his home in Preston, New York, after a short period at the Oxford Academy and a summer studying science with Amos Eaton at the Rensselaer School at Troy, through to his establishment in New Orleans and the death of his first wife. As a diary it moves from the impressions of an intensely personal, highly emotional youth groping through romance and futile longings toward the firmer foundation of a more matured and scientific outlook.

When finally the Journal ceases to serve as a record of Riddell's passing thoughts, diagrams of apparatus or inventions, mathematical solutions of problems including the plan for a journey to the moon, Riddell was established as a physician, as a professor in the Medical College of Louisiana, as scientific advisor on problems of health, and as a melter and refiner in the U. S. Branch Mint at New Orleans. By this time he was also a man of some wealth who gathered about him the less successful members of his family. Fragmentary and crude as the journal may be in certain ways, for it served Riddell largely as a medium for the development of his own personality, it is, nevertheless, an important scientific document in that it presents one man's first-hand record of the expanding field of science during the early nineteenth century. Since Riddell's training was in botany and medicine and since he practiced medicine he remained all of the time in touch with the people with whom he worked.

Because it is impossible to give more than a few brief abstracts of the journal itself, and since that does not cover certain of the more important of his scientific discoveries, more atten-

tion must be given to the period of his residence in Ohio for those were the formative years, leading to the accomplishments and the lasting fame he obtained during his later period in New Orleans. Volume I, entitled the "Repository—Part First—Natural Science," deals with the course pursued at Rensselaer School, Troy, July 15, 1829, under the tutelage of Eaton. His first sentence, which might have been paraphrased from Caesar's Commentaries reads, "Natural Science is divided into Natural History, Natural Philosophy and Chymistry." The first lecture is an analysis of a plant based on the Linnæan system. In this, however, Amos Eaton was using the familiar teaching device of setting up a straw man, merely to knock it down.

RIDDELL AND AMOS EATON

Riddell under Eaton learned and used all his life the system of Lindley which was just coming into use. Twelve years before in 1817, the members of Eaton's class at Williams College had grouped together and raised a small sum of money to publish what was the first really working *Manual* for the study of North American plants. Dr. L. C. Beck, later of St. Louis, and a student of Eaton's, said no other single book was so important in promoting an interest in botany. Eaton was aware that he was "the oldest teacher of popular botany in America." His first edition of the *Manual of Botany* was followed the next year by an Index to the *Geology of the Northern States.* At Troy, Eaton was the guiding spirit in the establishment of a Lyceum of Natural History and it was during this period of Eaton's teaching that modern geological surveys were projected. Thus, by an immense stroke of fortune, Riddell came into contact with the most distinguished teacher of science of his day in America.

YOUNG COCK'SCOMB

Eaton always had the reputation of unselfishly giving credit to those who worked with him and doing what he could to advance their interests. In the case of the 22-year-old Riddell one can see how this system worked on the minds of the impressed students, and especially one whose expanding ego was to grow as did that of the brilliant young Riddell. For an entry, dated August sixteenth in the Repository, just a month and a day after hearing Eaton's first lecture of the course Riddell notes: "*A new theory of the Earth,* given first by John L. Riddell in a lecture to the Rensselaer students." The oldest teacher of popular botany in America was again demonstrating that there are no great teachers, only unsurpassable students.

Riddell had only about a year of formalized schooling in all his life. His parents, John Riddell and Lephe Gates, were poor but not illiterate and with them and his Uncle Noyes he read winter after winter until he went to the Oxford Academy. His family must have given him a taste of good books, but he has left little for the biographer to build on in the way of plotting out his education. The use of good language came as naturally as breathing. His father, of Scotch-Irish forbears, was a small farmer and ten children followed after the birth of Riddell. There were always too many to feed and clothe to afford a formalized education of any completeness. But somehow John Riddell was given a brief period of education at the Rensselaer school at Troy.

ACQUAINTANCE WITH DOUGLAS HOUGHTON

The most distinguished schoolmate of Riddell at Troy was Douglas Houghton whose father had been a lawyer at Troy but who moved to Fredonia when Douglas was a boy. Douglas, however, after completing the work offered at the Fredonia Academy, had returned to the Rensselaer School and graduated in 1829. He remained as an assistant to Dr. Eaton in chemistry and was also engaged in the study of medicine, and was licensed to practice by the Chautauqua County Medical Society in 1830. Dr. Eaton sent him to Detroit to give a course of lectures on chemistry. What Houghton did in Michigan after he met Henry Rowe Schoolcraft and joined in exploring the copper region of Lake Superior and the headwaters of the Mississippi is not a part of this story. The main point is that contact at Troy with Eaton and with the youthful Douglas Houghton[5] helped set the pattern of Riddell's life. Riddell says hardly anything about Houghton in the Journal but always regards him favorably and likewise refers to him in the *Synopsis of Western Plants.*

(To be continued)

UNRRA in Need of Doctors

A number of positions are available under the United Nations Relief and Rehabilitation Administration for China, according to Dr. Goodrich C. Schauffler, Washington, field operations officer of the health division.

At present the Administration requires nutrition officers, public health engineers, consultants in tuberculosis, typhus, malaria, and maternal and child health; sanitary engineers, general surgeons, orthopedic surgeons, genito-urinary surgeons, and an obstetrician-gynecologist. Dr. Schauffler states that the categories for physicians call for clinical work, for the most part in connection with the universities in China. Inquiries may be addressed to the Administration at 1344 Connecticut Avenue, Washington 25, D. C.

Clip for Reference . . .

On the Record—The Federal Health Scheme

By DOROTHY THOMPSON

The phrase "economic bill of rights" has a magical quality like "liberal" and "progressive". Just attach one of these words to a measure, and critics back down as though before a fetish. But in a world where progress moves on crutches, conservatism may mean in some cases the last stand of liberty and common sense.

Few "liberals" are likely to reveal the illiberality of part of the proposed federal health scheme. Some of it is excellent. A widespread hospital construction program is urgently necessary, and for that government can make the economic grant of credit.

The national science research proposals are all right, if it is possible to keep the direction in the hands of competent medical scientists and not a political czar. Public health services for maternal and infant care can well be extended through federal grants in aid, and cash insurance against illness as part of unemployment compensation is reasonable.

A German Invention

But the main part of the proposed measures — universal compulsory federal insurance against illness of every wage and salary earner by a tax of 4 per cent on his income up to $3,600 will, if past experience elsewhere is a guide, mean vast overpayment for inferior services; that the poor pay for the rich, and not the other way around; and that income that should go for illness prevention in the form of nutrition, clothing and shelter will be forcibly extracted to pay for the results of deprivation.

The only people who will profit will be the new ranks of bureaucrats, two for every physician, supported by the people's contributions. The expenditure for ink will exceed that for iodine.

On the matter of state medical care through enforced contributions there is plenty of evidence. Like Communism and Naziism, it is a German invention arising out of Bismarck's concept of the providential state that would forever prevent revolt by tying the very existences of the people into it.

The state cannot create anything. Wealth is created by producers—industrial workers, management, and farmers. State insurances are a means whereby the state skims off their incomes and gives part back in services, many of which the people are better able to provide for themselves as individuals in cooperative groups.

Under the administration's plan everyone who works would, during the lifetime of his earning power, pay 4 per cent of his income up to $3,600. An employee with an income of $2,000 per year would pay $80. One with an income of $3,600 would pay $144. Everybody working would contribute—perhaps three or four of the same family. Any employee with an income above $3,600—a salaried man with an income of $10,000, a movie actor with income of $200,000—would also pay $144.

In private medicine, completely apart from the many co-operative non-profit group insurance schemes in operation, physicians daily perform millions of dollars worth of free services. Their wealthy patients help finance the indigent. This is not a proper situation, but it is more just than the government bill.

If the cost of the services offered in return for a 4 per cent of annual income are compared with those offered by the many co-operative schemes in existence, the price is exorbitant—as well as compulsory.

Mutual nonprofit schemes cover, for instance, some 23,000,000 industrial workers. One of these, under which 2,300 companies are insured, provides, for $60 per year, medical care for all workers plus their dependents, in home sickness, accident, hospitalization, surgical services—up to a fee of $150—laboratory fees up to $30 per year— and physicians' care up to 50 visits.

I myself am in a group insurance which provides hospitalization for my whole family for $24 per year.

Bureaucratic and Heartless

Co-operative medical schemes are voluntary, efficient, cheap of administration, and cheap for the participants and could be standardized on a high level. State schemes are bureaucratic, heartless, and open to dangerous collusion between assembly-line physicians and patients at the public cost—as those know who have lived under them.

The novelists are the best reporters. Those who think this proposal is "progress" should read "How Green Is My Valley", "Little Man What Now?" and "Karl and the Twentieth Century" for light.

Self-employed (farmers, for instance) are to pay 5 per cent of their incomes. On $3,600 that is $180 per year, or nearly 50 cents a day!

Ordinary bouts of sickness in the average family can be dealt with; the real crises are those that require hospitalization and surgical services, and these usually occur only a few times in one's life. Even as an individual, without benefit of group insurance, one can provide for a limited amount of miscellaneous services, operation costs, and 70 days of hospitalization for as low as $17 per year—depending on age and state of health—through private insurance companies.

Barnum said that a sucker is born every minute. Along with the sucker is born a politician, and nowadays a "progressive" to beat his drums for every measure that extends the power of the state even into the most intimate parts of life.

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HAVE YOU PAID YOUR 1946 DUES?

HAVE you kept your annual date with the Secretary-Treasurer of your County Medical Society?

In other words, have you paid your 1946 State Association and County Society dues?

Dues are due and payable on or before January 1 annually. To retain your name on the membership roster of the State Association, annual dues must be paid to your local Secretary-Treasurer for him to transmit to the Columbus office.

After March 1, *The Ohio State Medical Journal* can not be sent to unpaid members.

Therefore, it is important for all to pay their dues immediately. See your local Secretary-Treasurer about this today.

This warning does not apply to members still in Military Service or who did not start terminal leave prior to Dec. 31, 1945.

Employes of Hamilton Foundry and Tea and Spice Company In Cincinnati First to Sign Up With Ohio Medical Indemnity Inc.; Great Interest Shown In Area

ENROLLMENT of the first groups of subscribers, whose contracts will take effect February 15, has been announced by Mr. Charles H. Coghlan, executive vice-president of Ohio Medical Indemnity, Inc.

The distinction of being the first group to sign up with Ohio Medical Indemnity, Inc., which was organized by the medical profession of Ohio, goes to the employes of the Hamilton Foundry and Machine Co., Hamilton, and the Frank Tea and Spice Co., Cincinnati.

As a result of the fine cooperation displayed by the officials of these two companies and the widespread interest demonstrated by the employes themselves, in excess of 50 per cent of the employes of each company were enrolled during the initial enrollment campaign.

As this issue of The Journal went to press, enrollment cards were being checked, preparatory to issuing the indemnity contracts. It is estimated that between 1,500 and 2,000 persons, including employes and members of their families, will be covered under the two initial agreements consummated by Ohio Medical Indemnity, Inc.

According to Mr. Earl Kammer, general agent for Ohio Medical Indemnity, Inc., in Southwestern Ohio and enrollment director of Hospital Care Corporation, Cincinnati, the facilities of which are being utilized by Ohio Medical Indemnity, Inc., on administrative, clerical and enrollment details, great interest is being shown in the program of Ohio Medical Indemnity, Inc., by the people of the 14-county area.

Because of the fine publicity which has been given to this program of the medical profession to provide cash indemnities against medical, surgical and obstetrical expenses by the newspapers of that section of Ohio, the office of Hospital Care Corporation of Cincinnati, which is being used by Ohio Medical Indemnity, Inc., as its district office, is receiving numerous telephone calls and inquiries about the program. Numerous meetings of groups of subscribers to Blue Cross Hospitalization coverage have been held at which much enthusiasm was displayed. Also, many employers of the area have expressed considerable interest in the company and its coverage. Early enrollment of additional substantial groups is anticipated.

Suggestions for Physicians Relative to Federal Income Tax Law Procedures, Payments and Deductions

UNDER the provisions of the Revenue Act of 1945, every person whose 1945 gross income was $500 or more, must, not later than March 15, 1946, file certain returns with the District Collector of Internal Revenue for the district in which the taxpayer resides.

The Journal urges every physician to obtain advice and assistance from competent legal or tax authorities or staff members in the offices of the District Collectors of Internal Revenue in the preparation of his return. With the high rates and possible penalties involved, it is most important that every physician be certain that his income tax returns are prepared accurately and carefully.

Based on information obtained from Mr. S. F. Noggle, Columbus, for many years chief of Income Tax for the 11th Ohio Internal Revenue District, *The Journal* presents the following high spots of the income tax law, with an explanation of the items which physicians in private practice can properly deduct as business expense from gross income.

FORMS AND PAYMENTS

Not later than March 15, 1946, every physician who comes within the provisions of the Income Tax Law, must do the following:

1. File an actual return, on Form 1040, for 1945.

2. Pay the difference, if any, between the income tax paid during 1945, based on the estimated return for 1945 which he filed during that year and the amount of the tax computed on his final return for 1945 filed on or before March 15, 1946. If he has overpaid, the excess amount will be refunded or credited against future tax payments. Amounts refunded carry interest at six per cent from March 15, 1946, to date of payment.

3. File a declaration of estimated tax for the year 1946, and pay one-fourth of the estimated tax for 1946, the balance payable quarterly thereafter. Blanks for filing the 1946 return have been mailed to taxpayers of record by the district collectors of internal revenue. If estimated returns for 1946 are based on 1945 income and the tax computed at the 1946 rates, no penalty will be assessed even though the estimated tax is understated by more than 20 per cent.

THOSE PAID A SALARY

Any individual whose earnings are subject to withholding, e.g., a physician in a salaried position, and whose earnings are not in excess of $5,000, may elect to make a return simply by supplying the information required on the withholding receipt furnished by his employer, W-2, (rev.), and forwarding the original copy to the office of the district collector. The tax will be computed and any amount due over the withholding will be assessed against the taxpayer, or if the withholding is in excess of the actual tax due, a refund of the over-payment will be made.

REPORT ON FUNDS PAID

While it is not necessary this year to report salaries of office assistants and other employees whose salaries are subject to the withholding tax, as in previous years payments in excess of $500 made during 1945 for interest, rents or commissions, not subject to withholding and paid to anyone other than a corporation, must be reported on Form 1099 and transmitted with Form 1096, on or before February 15, 1946, to the Commissioner of Internal Revenue, Sorting Section, Washington, D.C.

DISTRICT OFFICES AND DISTRICTS

Income tax payments and returns must be made at the office of the District Collector of Internal Revenue for the district in which the taxpayer has his legal residence. There are four internal revenue districts in Ohio. The counties comprising each district follow:

For the Columbus District (Ohio 11th) Collector of Internal Revenue, Federal Building, Water and Gay Sts., Columbus; comprising the following counties:

Adams, Athens, Coshocton, Delaware, Fairfield, Franklin, Gallia, Guernsey, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton and Washington.

For the Cleveland District (Ohio 18th) Collector of Internal Revenue, 262 Federal Building, Cleveland; comprising the following counties:

Ashland, Ashtabula, Belmont, Carroll, Columbiana, Cuyahoga, Geauga, Harrison, Holmes, Jefferson, Lake, Lorain, Mahoning, Medina, Monroe, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas and Wayne.

For the Cincinnati District (Ohio 1st) Collector of Internal Revenue, Customs Building, Cincinnati; comprising the following counties:

Brown, Butler, Clark, Clermont, Clinton, Fayette, Greene, Hamilton, Highland, Miami, Montgomery, Preble and Warren.

For the Toledo District (Ohio 10th) Collector of Internal Revenue, Toledo; comprising the following counties:

Allen, Auglaize, Champaign, Crawford, Darke, Defiance, Erie, Fulton, Hancock, Hardin, Henry,

Huron, Logan, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Shelby, Van Wert, Williams, Wood and Wyandot.

THOSE IN MILITARY SERVICE

A physician who is on active military duty should file his income tax return in the office of the Collector of Internal Revenue of the district in which he was a legal resident immediately prior to his entrance into active service. Compensation received for military service is subject to income tax.

Members of the armed forces who are on duty outside the continental limits of the United States are not required to file a return on military pay until the 15th day of the sixth month following their return to this country.

Men in the service, and who are commissioned, are permitted a deduction of $1,500 from gross service income, in addition to the usual personal exemption and the credit for dependents. Those below the rank of a commissioned officer do not pay tax on military pay.

If a commissioned officer does have to pay a tax on his active service pay, received as a commissioned officer for any year after December 31, 1939, and before January 1, 1947, the time for paying can be extended by payment of equal installments every three months for 36 months.

To obtain this extension, the officer must file an application with the Collector of Internal Revenue for his district.

DEDUCTIBLE ITEMS

In computing net income, the following items may be deducted by a physician from gross income:

Office Rental—If a physician pays rent to another person for office space, he may deduct such amount. If he rents a combined home and office, he may deduct that portion of the rent charged for the office. If he owns his own home and maintains an office in it, he **can not** claim deduction for office rent. However, he is entitled to claim depreciation on that portion of the property occupied as an office.

Automobile—The cost of repair and upkeep of an automobile, including gasoline and oil, used in professional visits may be deducted. That part of the salary paid to a chauffeur and attributable to time spent in driving his employer on professional calls, may be deducted. Sums spent for taxi hire, car fare, etc., while on professional calls, may be deducted.

Loss on an automobile used in professional business through depreciation may be deducted. The depreciation which should be deducted annually is figured by dividing the cost price of the machine by the number of years of its usefulness. If a physician has one automobile which is used exclusively in professional business, he may deduct the full depreciation each year. If the machine is used only partly in professional business, the deductible depreciation should be computed on the basis of the amount of time the car is used for professional purposes. If a physician possesses two cars, each of which is used partly in professional business, the deductible depreciation on each car should be computed on the basis of the amount of time each car is used for professional purposes. In other words, if an automobile is used only partly for business purposes, depreciation may be deducted only on a proportionate part thereof, the amount of depreciation depending on the amount of time the machine is used in professional business.

A loss occasioned by damage to an automobile maintained either for business or pleasure, which is not due to the willful act or negligence of the taxpayer, is deductible loss in the computation of net income, provided the taxpayer has not been reimbursed for such loss by insurance.

It is suggested that physicians be prepared to substantiate claims for deductions from gross income for professional use of automobiles in case income tax officials should call on them for written records to show the mileage traveled by them in connection with professional practice, or to prove just what part of their automobile maintenance expense was a professional expense, and therefore deductible.

Professional Dues—Dues paid to professional associations to which, in the interest of his profession, the physician belongs, may be deducted. Expenses incurred in taking graduate courses have been held **not** to be deductible.

Traveling Expenses—Traveling expenses necessarily incurred by a physician on professional calls and in **attending medical conventions for a professional purpose** are deductible from gross income.

Salaries and Wages—Deductions are permitted for the salaries or wages of nurses, laboratory workers, technicians, assistants, stenographers, or other clerical workers in a physician's office so long as their duties are connected with professional work; also for wages paid maids, janitors, etc., for services rendered in connection with professional practice.

Medicines, Supplies, Etc.—Cost of medicines used in the office to treat patients, medicine dispensed, bandages, laboratory materials, chemicals, and other supplies "consumed in the using" and necessary to operate the office may be deducted.

Equipment, Furniture, Library, Etc.—Cost of surgical instruments and laboratory appliances of more or less permanent value may not be deducted but a percentage of the purchase price may be deducted annually under a depreciation account. The same rule applies to office furni-

ture and books purchased for the physician's office library. If improvement to offset obsolescence and wear and tear or injury has been made and deduction for the cost claimed elsewhere in the return, claim should not be made for depreciation.

General Office Expenses—The cost of telephone, telegrams, heat, light, water, etc., used in professional services is deductible. Physicians who keep current magazines and newspapers in their waiting rooms for the benefit of their patients, may deduct this item as a business expense. The cost of professional journals for the physician's own use is also a deductible item.

Debts—If the physician's books are kept according to the "Cash Receipts and Disbursements" system, he may not charge off any unpaid debt because he is then only reporting as gross income those accounts which have proved to be good. Bad accounts have not been reported and are therefore not deductible.

If books are kept on an "Accrual Basis" (where expense is actually incurred and payable even though not yet paid, or income earned although not yet collected) it is permissible to charge off all debts which have been definitely ascertained to be worthless during the fiscal year covered by the report.

The physician using this latter system must be careful to include in gross income bad debts which have been charged off in previous years but collected during the calendar year for which the return is filed.

Taxes and Licenses—All state and county taxes, except those assessed against local benefits of a kind tending to increase the value of the property assessed and those imposed upon the taxpayer upon his interest as shareholders of a corporation which are paid by the corporation without reimbursement from the taxpayer, are deductible.

Sales Tax payments may be deducted. A reasonable allowance will be permitted in proportion to the physician's income. Should the claimed exemption appear too large, however, the burden of proof falls upon the taxpayer, and **he may be called upon to produce purchase receipts to substantiate his claim.** Sales tax coupons **are not** considered sufficient evidence.

The Ohio Gasoline Tax is deductible to the extent of four cents per gallon. If a physician has already deducted the cost of gasoline used in making professional calls as automobile expense, he can not of course make an additional deduction of four cents per gallon for gasoline so used. However, he may deduct that amount on gasoline purchased for other than professional use.

All license fees which the physician is required to pay are deductible, including the narcotic tax, automobile license tag fee, local occupational taxes, taxes on club dues, etc.

Under the present Income Tax Act, such Federal taxes as the auto use tax, amusement taxes, and taxes on club dues and long distance telephone tolls are no longer deductible items. However, deductions may be made for taxes on telephone tolls covering calls for business or professional purposes, and which calls are in themselves deductible as business expense.

Federal Old Age Benefits and Unemployment Compensation Taxes paid by employers under the Social Security Act are proper deductions in making income tax returns. Such taxes are deductible on returns for the taxable year in which they are accrued or paid, depending upon the method of accounting employed by the taxpayer. However, Federal Old Age Benefits payroll deductions from employees' wages are not proper deductions from individual employee's Federal income tax returns. The reason for this latter distinction is that the individual employee at a future date will have returned to him in the form of pensions the money which is deducted from his current wages.

Interest—Amounts paid out as interest upon indebtedness (except interest paid to carry nontaxable securities) are deductible.

Losses by Fire and Theft—Loss or damage to a physician's equipment by fire, theft, or other cause, not compensable by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent to which it has not been made good by repair and the cost of the repair is claimed as a deduction.

Insurance Premiums—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment, and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are not deductible.

Legal Expenses—Expense incurred in the defense of a suit for alleged malpractice is deductible as business expense. However, expense incurred in the defense of a criminal action is **not** deductible.

Contributions, Gifts, Etc.—It is permissible to deduct from gross income contributions made to charitable, religious, educational and scientific organizations, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting to influence legislation, to an

aggregate amount not to exceed 15 per cent of the adjusted gross income.

Optional Standard Deduction—Under the present law a taxpayer may elect in lieu of listing ordinary deductions such as contributions, interest and taxes, to take advantage of the optional deduction of 10 per cent of his adjusted gross income, up to a total of $500. If the adjusted gross income is less than $5,000, and the taxpayer elects to take the optional standard deduction, the amount of the tax will be found on the table on Page 4 of income tax return Form 1040.

Medical and Dental Expenses—Deduction is permitted for extraordinary medical-dental expenses paid during the year, not compensated for by insurance or otherwise, which are in excess of five per cent of the aggregate adjusted gross income. In the case of a husband and wife the expenses are not deductible unless they exceed five per cent of the aggregate adjusted gross income of both. The maximum allowable deduction on a joint return or the return of a head of a family is $2,500, and for a single person, $1,250. The term "medical care" as used in the act, is broadly defined to "include amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body (including amounts paid for accident or health insurance)".

In order to obtain this credit for medical and dental expenses, the taxpayer is required to list the name and address of the person to whom the payment is made, the approximate date of actual payment and the amount. It should be noted that this will furnish the Internal Revenue Department with data which can be used in checking returns filed by physicians and dentists—another reason why they should keep accurate records and compile their returns carefully.

A special deduction of $500 is allowable to a taxpayer who was blind on July 1, 1945.

SOME RELIEF FOR 1946

The principal changes affecting individuals resulting from amendments made by the Revenue Act of 1945 involve reduction of the surtax rate in each bracket by three per cent, and an overall reduction of five per cent in the amount of normal tax and surtax.

It must be remembered, however, that these changes apply to estimated returns for the calendar year 1946, to be filed on or before March 15, 1947, and have no effect on the actual returns for the calendar year 1945, which are being filed on or before March 15, 1946.

Additional relief for the taxpayer's 1946 income may be derived from the fact that the taxpayer will be allowed the same exemptions for normal tax as for surtax. In some cases this will result in a decrease in the normal tax.

While for 1945, the total normal tax and surtax can not exceed 90 per cent of net income, in 1946 and thereafter, these taxes can not exceed 85½ per cent.

OLD AGE BENEFITS TAX

The Old Age Benefits Tax is payable by every physician who employs one or more persons in his office. It amounts to one per cent on the first $3,000 of each employee's wage paid by the employer and a like amount deducted from the wages of each employee. The tax return and informational return, combined in one report, Form SS-1-A, to be filed **quarterly.** The tax must be paid and the return filed prior to April 30, 1946, for the months of January, February and March, 1946, in the office of the District Collector of Internal Revenue, and quarterly thereafter, payable the month after the quarter ends.

UNEMPLOYMENT COMPENSATION TAX

Under the Ohio Unemployment Compensation Law, physicians who employ three or more persons must file an "Employer's Contribution, Form UCO-2-e, Report", and Form BUC-75 report of individual worker's wages, **quarterly** with the Ohio Bureau of Unemployment Compensation, Columbus. Contribution reports for any calendar quarter are due within the month immediately following the quarter. The tax, which must accompany the return, amounts to 2.7 per cent of the quarterly payroll, unless qualified for a modified rating, known as the experience rating.

Employers of eight or more persons in 20 weeks during a calendar year, under the Federal Unemployment Excise Tax, must have filed with the District Collector of Internal Revenue on Form No. 940, prior to January 31 of each year, a report of wages paid during the preceding year.

The tax is three per cent, less a credit amounting to 90 per cent of the Federal tax if the employer of eight or more has paid his contributions in full to the Ohio Bureau of Unemployment Compensation. In effect, any such employers whose state tax liability is paid in full need pay a rate of only three-tenths of one per cent under the Federal tax act.

OHIO USE TAX

The Ohio Use Tax Law, passed in 1936, supplementing the Retail Sales Tax Law, imposes a tax on the same basis as the sales tax, on purchases made outside the state. Its purpose is to protect Ohio merchants from discrimination. Many out-of-state firms have made arrangements with the Ohio Department of Taxation to add the amount of the tax to invoices covering purchases

by Ohio consumers, collecting the tax and paying it directly to the Department. **However, if a physician purchases drugs or supplies from an out-of-state firm which has not made such an arrangement with the Tax Department, he is required to report such purchases to the Tax Department and pay the tax. Returns must be filed with the Department by April 15, 1946, for purchases during the period January 1 to March 31, 1946, and quarterly thereafter.**

OHIO PERSONAL PROPERTY TAX

There have been no fundamental changes in the Ohio Personal Property Tax provisions. However, a new simplified form has been instituted.

Returns under the Ohio Personal Property Tax Law must be made between February 15 and March 31, annually.

All tangible and intangible personal property (not real property) in possession of a physician on January 1, 1946, which is subject to taxation under the Ohio law, should be listed on the return which should be filed with the county auditor between those dates. Form 910 is used by individuals and partnerships, and Form 930 by corporations.

Such returns should be made in duplicate. The so-called intangible tax statutes are intricate and complicated so each physician having taxable personal property for listing should obtain competent advice in case of doubt as to the meaning of any of the provisions of the law.

One of the complicated provisions of the tax law is that involving the listing of credits which are taxable at 3 mills on the dollar and which involves the computation of accounts receivable.

As defined in Section 5327 of the law, credits "mean the excess of the sum of all current accounts receivable and prepaid items used in business when added together estimating every such account and item at its true value in money, over and above the sum of current accounts payable of the business, other than taxes and assessments".

The same section states that "current accounts include items receivable or payable on demand or within one year from the date of inception, however evidenced".

As the first step in making his return under the section relating to credits, a physician should estimate by his best judgment the **Actual Value** of his current accounts receivable—the amount that probably can be collected.

In listing his current accounts receivable, the physician should note after each account what he considers the value of the account. If he believes the account can be collected in full, it should be listed at its full face value. Otherwise, it should be listed at 75%, 50%, 25%, 10%, etc., of its full face value, or of "no value" in case that is considered the "actual value" of the account. The total of these estimates is the total to be entered as "current accounts receivable" and used in computing credits.

This procedure permits the physician to charge off bad debts since in his 1945 return he would be permitted to return as of "no value" accounts receivable which he listed in 1944 but no part of which was collected during the past year. Moreover, it permits a physician to depreciate the actual value of accounts returned in 1944 but which have decreased in actual value during the past year.

Emergency V.D. Hospital To Be Opened By State Near Columbus

As an emergency measure for the treatment of venereal diseases in central and rural Ohio, a 100-bed hospital is to be established in excess buildings at the Lockbourne Army Air Base, a few miles south of Columbus.

At the request of the State Department of Health, the U. S. Public Health Service is providing 80 per cent of the estimated $120,000 annual cost in order that rapid treatment may be carried on until Ohio's general hospitals are in a position to take it over.

Scheduled to open February 15, the hospital will operate on a free basis and for three categories of patients, according to Dr. John D. Porterfield, chief of the venereal disease division, State Health Department, but will not compete with physicians in private practice.

Physicians throughout the state will be invited to visit the hospital to view the technic and results of rapid treatment as well as the operation of the small neurosyphilis department which is included in the project.

Patients of the clinic will fall into these categories: First, service men being discharged and who have doubtful blood tests occurring in the physical examination at separation center. Those in this class who wish to avail themselves of the service will receive diagnosis and treatment when indicated.

Second on the list will be clinic patients, referred to the hospital to assure that they will continue regimen until fully recovered.

Third, will be those patients referred to the hospital by physicians themselves. If a positive laboratory report has been returned, doctors may request admission for patients by calling the State Health Department, or by consulting with a local clinic. If possible, patients will be expected to pay their own transportation.

Captain Fred C. Kluth, a U. S. Public Health Service officer, will be in charge of a staff of 40 to 50 including one full-time physician and one part-time.

Joint Committee Formed To Sponsor Program for Improved Tuberculosis Control in Ohio; Objectives Outlined

THREE representatives of the Ohio State Medical Association have been appointed by President L. H. Schriver on authorization of The Council as members of a newly-organized Joint Committee on Tuberculosis Control in Ohio, composed of representatives of seven state organizations especially interested in formulating a modern, efficient tuberculosis control program for Ohio for consideration by the legislative and executive branches of the state government.

Those selected to represent the Ohio State Medical Association on the joint committee are: Dr. J. L. Webb, Nelsonville; Dr. C. E. Hufford, Toledo; and Charles S. Nelson, executive secretary of the State Association.

OTHER MEMBERS OF COMMITTEE

In addition to the Ohio State Medical Association, the joint committee includes the:

Ohio Federation of Public Health Officials, represented by Carl A. Wilzbach, M.D., health commissioner, Cincinnati; Walter H. Hartung, M.D., health commissioner, Toledo; H. G. Southard, M.D., health commissioner of Hocking and Vinton Counties.

Ohio Hospital Association, represented by H. L. Rockwood, M.D., superintendent, Warrensville Chronic Disease Hospital; Louis Blair, superintendent, University Hospital, Columbus; L. C. Rittmeyer, administrator, Dunham Hospital, Cincinnati.

Ohio State Nurses' Association, represented by Mrs. Esther Brubaker, R.N., Springfield; Miss Vera Glover, R.N., Cuyahoga County Board of Health, Cleveland; Miss Mildred Lambert, R.N., Dunham Hospital, Cincinnati.

Ohio Conference of Tuberculosis Secretaries, represented by Whitney H. Herr, executive secretary, Mahoning County Tuberculosis Association, Youngstown; J. Dean Halliday, director of public relations, Anti-Tuberculosis League of Cleveland and Cuyahoga County, Cleveland; Nona C. Simmerman, executive secretary, Montgomery County Tuberculosis Association, Dayton.

Ohio Public Health Association, represented by Wm. M. Morgan, Ph.D., Alliance; Azel Ames, M.D., Hamilton; George L. Lafferty, Lisbon.

Ohio Tuberculosis Hospital Association, represented by H. H. Brueckner, M.D., superintendent, District Tuberculosis Hospital, Lima; E. F. Conlogue, M.D., superintendent, Stillwater Sanatorium, Dayton; William L. Potts, M.D., superintendent, Franklin County Sanatorium, Columbus.

Serving in an advisory capacity from the Ohio Department of Health are: Roger E. Heering, M.D., director; J. E. Bauman, chief, Division of Administration; and Mark W. Garry, M.D., chief, Division of Tuberculosis.

OHIO HAS POOR RECORD

Ohio's unenviable position at the bottom of the list in its expenditures and facilities for the prevention of tuberculosis and the care of tuberculous patients motivated the creation of the joint committee, especially after bills which would have improved the Ohio situation failed in passage at the 1945 session of the Ohio General Assembly.

Unofficially, representatives of the seven organizations met in November, 1945, to review the situation. Dr. Wilzbach was asked to serve as chairman of the joint committee and the Ohio Department of Health was requested to draft a proposed program and present it to the committee for approval.

PROGRAM FORMULATED

State Director of Health Heering and Dr. Garry formulated the following recommendations which were approved on December 20 by the joint committee, the objectives of which now will be to sponsor legislation before the General Assembly to carry out the program:

1. That a 300-bed hospital for the tuberculous be erected in conjunction with the Ohio State University Medical Center at Columbus.

2. That at other designated locations in the state, four 200-bed hospitals for the care of the tuberculous be built. These five hospitals would be available to all residents of the State of Ohio and the maintenance of which would be provided by the state without cost to the local governmental units.

3. That a subsidy of $2.50 per patient day be provided by the state to be paid to the commissioners of the county of residence of the patient for care in a county, district or other hospital for the tuberculous, approved by the Ohio Department of Health.

4. That a regular appropriation of $50,000 per annum be provided for the operation of the Division of Tuberculosis of the Ohio Department of Health.

5. That it shall be the duty of the county commissioners or other agency in charge of local relief funds on recommendation of local health authority to provide assistance from public funds to families of hospitalized tuberculous breadwinners.

Campaign plans of the committee include the formation of an organization in every county to sponsor the legislation and see that it is passed.

Each county committee will be a counterpart of the state committee insofar as it is possible. Dr. Wilzbach is planning to send requests to the county representatives of each of the seven associations on the state committee asking that they cooperate with the chairman on the local level when the appointment is made and the campaign is launched.

DATA SHOWS WEAKNESSES

Studies made by the committee reveal that at present the Division of Tuberculosis of the Ohio Department of Health has no operating funds other than those derived from the United States Public Health Service; that no provision is made by the state to care for tuberculous cases from counties where there are no sanatoria; that lack of a state subsidy by the state to local communities places an unequal burden of financing upon the various counties; that the poorer counties are left without sanatoria facilities, depending entirely on richer neighboring areas for the care of patients; that this situation reduces the number of beds necessary for adequate hospitalization of the tuberculous; that there is no centrally located tuberculosis hospitals where patients from all sections of the state may be cared for and where physicians can observe clinic patients and derive information and training on new techniques.

Data assembled also shows that in 1944 there were 2,754 deaths from tuberculosis in Ohio or a rate of 39.2 per hundred thousand population. In addition there were almost two and one-half times as many new cases reported in the same period or about 6,885. To meet this problem, Ohio had but 3,816 beds for the tuberculous as of September, 1945. This is less than one and a half beds for each annual death against an accepted national standard of three beds per death.

COMING MEETINGS

Ohio State Medical Association, Columbus, May 7-9.

American Medical Association, San Francisco, July 1-5.

American Association of Pathologists and Bacteriologists, Cleveland, March 8-9.

American Association for Thoracic Surgery. Detroit, May 29-31.

American College of Physicians, Philadelphia, May 13-17.

Annual Congress on Medical Education and Licensure, Chicago, Feb. 11.

American Dietetic Association, Cincinnati, Oct. 14-18.

Conference of State Secretaries and Editors, Chicago, Feb. 8-9.

National Conference on Medical Service, Chicago, Feb. 10.

Mr. Hart F. Page Joins Staff as News Editor and Assistant in Public Relations

Employment of Mr. Hart F. Page, Columbus, as News Editor of *The Ohio State Medical Journal* and assistant to the Director of the Department of Public Relations of the Ohio State Medical Association, is the second step of The Council's program for expanding the services and facilities of the Association, especially in the field of public relations.

At its December, 1945, meeting, The Council appointed Mr. George H. Saville, who has served as assistant executive secretary for the past 11 years, as director of the Department of Public Relations. Mr. Saville will continue to serve as assistant executive secretary.

At the same meeting, The Council adopted a resolution recommending to the House of Delegates that it authorize an increase in the annual dues of the Association to $15.00 when it meets during the 1946 Annual Meeting in Columbus, May 7, 8 and 9. If approved by the House of Delegates, the increased dues will become effective January 1, 1947. If the House of Delegates decides to increase the annual dues, steps will be taken immediately by The Council to expand the public relations activities of the Association in anticipation of adequate revenue for current financing of such activities at a later date.

The employment of Mr. Page on a full-time basis and the contemplated addition to the Columbus office staff of other personnel will enable Mr. Saville to devote much of his time to public relations work and enable Executive Secretary Nelson to engage in more field work among the county medical societies and to devote more attention to the work of the various State Association committees.

Mr. Page, who is married and the father of one child, graduated from Ohio State University in 1938 with the degree of B.Sc. in Journalism, following three years' experience on the university daily. Following his graduation, Mr. Page joined the headquarters staff of the Ohio State Grange. He served as associate editor and business manager of the *Ohio State Grange Monthly;* directed radio broadcasts; assisted in legislative activities and public relations work; edited various folders and pamphlets for distribution to members of the Grange and to the public generally.

In 1942, Mr. Page enlisted in the Navy where he served for 38 months as publicity yeoman, handling newspaper and magazine releases, radio programs, etc., and, later, on overseas duty, as landing craft engineer and watch officer.

Prior to entering the Navy, Mr. Page also served for a year as editor of the Columbus Junior Chamber of Commerce magazine, *The Vibrator,* and as director in charge of publicity.

Now Is the Time To Make Hotel Reservations for the Centennial Anniversary Meeting at Columbus, May 7-9

TO obtain best hotel accommodations for the Centennial Anniversary Meeting of the Ohio State Medical Association, May 7, 8, and 9, reservations should be requested at once.

Celebrating 100 years of medical progress in Ohio, this will undoubtedly be one of the greatest State Meetings in the Association's history. Plans are already well along for a top-notch program, scheduled to take place in the Neil House and the Deshler-Wallick Hotels, Columbus.

In order to insure obtaining the type of accommodations you will require, make a request for reservations—**immediately**—to the hotel of your choice. Look over the accompanying list of Columbus hotels and address your request on the attached blank to the management of the hotel selected.

NAME AND LOCATION	No. of Rooms	Single	Double	Double Twin Beds	Suites
NEIL HOUSE 35 South High St.	665	$4.40-7.70	$5.00-9.00	$5.50-11.00	Rates on request
DESHLER-WALLICK Broad and High Sts.	1000	3.30-8.80	5.50-11.00	5.50-13.20	Rates on request
FORT HAYES 31 W. Spring St.	350	3.00 and up	4.50 and up	5.00 and up	7.00-20.00
CHITTENDEN High and Spring Sts.	275	2.00-3.00	3.00-4.00	3.50-6.00	
SENECA 361 E. Broad St.	250	2.50-4.00	4.00-5.00	5.00-6.00	8.00-12.00
SOUTHERN High and Main Sts.	250	2.50-3.00	3.50-4.00	4.00-4.50	
VIRGINIA Third and Gay Sts.	150	2.20 and up	3.30 and up	4.40 and up	
BROAD-LINCOLN 631 E. Broad St.	140	2.20 and up	3.30 and up	4.95 and up	3.85 and up

HOTEL RESERVATION BLANK

Mail this coupon to hotel selected

Manager _____ **Hotel, Columbus, Ohio.**

You are requested to reserve the following accommodations during the period of the Centennial Anniversary Meeting of the Ohio State Medical Association, May 7, 8 and 9, 1946, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double room with bath Price: _____

☐ Twin Bed Room with bath ☐ Suite

Arriving May _____ at _____ A. M. _____ P. M.

PLEASE VERIFY MY RESERVATION.

Name _____

Address _____

_____

Improvements in Veterans Administration Hospitals Are Anticipated Under Law Recently Passed by Congress

LEGISLATION creating a Department of Medicine and Surgery in the Veterans Administration, sponsored by Generals Omar N. Bradley and Paul R. Hawley of the Veterans Administration, has been enacted by Congress and signed by the President (H.R. 4717).

In the opinion of General Hawley, appointed chief medical director under the new legislation, the new setup will be of material assistance to the Veterans Administration in obtaining additional medical personnel for existing veterans' hospitals which are understaffed at present.

In general the new law contains provisions for organization and authority without military aspects; provides a more adequate salary schedule; authorizes appointments in certain positions without regard for Civil Service; retains Civil Service provisions for unexempted positions; offers a Civil Service retirement plan instead of a military retirement program; provides authority for discharge of unsatisfactory or disqualified personnel without regard for Civil Service; and contains provisions for postgraduate education opportunities for professional personnel.

Detailed provisions of the new law are as follows:

DEPARTMENT OF MEDICINE AND SURGERY

The new department will include an Office of the Chief Medical Director, Medical Service, Dental Service, Nursing Service and Auxiliary Service. The Chief and Deputy Medical Directors must be qualified doctors of medicine and will be paid a salary of $12,000 and $11,500 a year, respectively. Provision is made for the appointment of eight Assistant Medical Directors, one of whom will be a qualified doctor of dental surgery and will be directly responsible to the Chief Medical Director for the operation of the Dental Service. Each such Assistant Medical Director will be paid a salary of $11,000 a year. There will be a Director and Deputy Director of Nursing Service at a salary of $8,000 and $7,000 a year, respectively. A Chief Pharmacist, Chief Dietitian, Chief Physical Therapist and a Chief Occupational Therapist will each be paid a salary of $6,000 a year. All of these appointments will be made by the Administrator of Veterans' Affairs for a four-year period, and reappointments may be made for successive like periods. The Administrator may remove an appointee for cause.

Section 4 authorizes the employment of additional personnel, including doctors, dentists, nurses, managers of hospitals, homes and centers, pharmacists, physical therapists, occupational therapists, dietitians, pathologists, bacteriologists, chemists, biostatisticians and other medical and dental technologists.

QUALIFICATIONS FOR APPOINTMENT

A person to be eligible for appointment to the Department of Medicine and Surgery must be a citizen of the United States. For appointment in the Medical Service, the appointee must hold the degree of doctor of medicine or of doctor of osteopathy from a college or university approved by the Administrator, have completed an internship satisfactory to the Administrator and be licensed to practice medicine, surgery or osteopathy in one of the states or territories of the United States or in the District of Columbia. Similar qualifications are included to apply to appointments in the Dental Service, in the Nursing Service and in the Auxiliary Service. Persons on terminal leave from the armed forces may be appointed and may be paid for their services rendered under such appointment notwithstanding any law or regulation to the contrary.

Appointments of physicians, dentists and nurses will be made only after qualifications have been satisfactorily established in accordance with regulations prescribed by the Administrator and without regard to civil service requirements. Appointments authorized by section 4 will be for a probationary period of three years. The record of each person serving under an appointment in the Medical, Dental and Nursing services will be reviewed from time to time by a board appointed in accordance with regulations by the Administrator. If the board finds any appointee not fully qualified and satisfactory, he will be separated from the service. Physicians, dentists and nurses serving in the present Medical Service will be continued in their present positions until the Administrator shall have determined their qualifications.

PROMOTIONS

Promotions of physicians, dentists and nurses will be made only after examination given in accordance with regulations prescribed by the Administrator. Automatic promotions within grade may be made in increments of the minimum pay of the grade in accordance with the regulations.

PRESERVATION OF CIVIL SERVICE STATUS

The new law provides for the protection of Civil Service reinstatement rights in cases of those who at the time of appointment have a

Civil Service status and whose employment in the department is not continued.

GRADES AND PAY RANGES

In the Medical Service there will be six grades beginning with the junior grade with a minimum salary of $3,640 and advancing to the chief grade, with a maximum salary of $9,800. In the Dental Service there will be five grades, ranging from the junior grade with a minimum salary of $3,640 to the senior grade with a maximum salary of $8,225. In the Nursing Service there will be four grades, ranging from junior grade with a minimum salary of $2,320 to senior grade with a maximum of $5,180. There is provision, in addition, for an Assistant Director of the Nursing Service with a salary range from $5,180 to $6,020.

The Administrator will be authorized to prescribe by regulation the hours and conditions of employment and leaves of absence of physicians, dentists and nurses.

RATING AS SPECIALISTS

The Chief Medical Director will be authorized to rate any physician appointed under section 4 as a medical or surgical specialist. No such rating may normally be given unless the physician is certified as a specialist by an American specialty board. In event that no such board exists, the rating may be given if the physician has been examined and found qualified by a board appointed by the Chief Medical Director from specialists of the Department of Medicine and Surgery holding ratings in the specialty to which the candidate aspires. In case there are insufficient specialists to constitute such a board, the Chief Medical Director may substitute consultants with comparable qualifications employed on a temporary full-time, part-time or fee basis.

Physicians to whom such specialist rating is given will hold it until it is withdrawn by the Chief Medical Director after a determination has been reached by a board of specialists that the physician is no longer qualified in this specialty.

Physicians who are given the rating of specialists will be entitled, in addition to their basic pay, to an allowance equal to 25 per cent of such pay, subject to the restriction that the basic pay plus the allowance may not exceed $11,000 a year.

CIVIL SERVICE RETIREMENT BENEFITS

Persons appointed to the Department of Medicine and Surgery will be subject to the provisions of and entitled to benefits under the Civil Service Retirement Act of May 22, 1920.

DISCIPLINARY BOARDS

The Chief Medical Director will be authorized to appoint disciplinary boards to determine, on notice and fair hearing, charges of inaptitude, inefficiency or misconduct. Each board will consist of not less than three nor more than five employees, senior in grade, of the Department of Medicine and Surgery. The Administrator will appoint a chairman and secretary of each board, who will have authority to administer oaths. The Chief Medical Director may appoint one or more investigators to assist in the collection and presentation of evidence, and every person against whom charges are made may be represented at the hearing by counsel of his own choice. A disciplinary board may recommend reprimand, suspension without pay, reduction in grade, and discharge from the Department of Medicine and Surgery. The Administrator will be required either to approve the recommendation as made, approve it with modification or exception, approve it and suspend further action at the time, or disapprove such recommendation; and the decision of the Administrator will be final.

APPOINTMENT OF ADDITIONAL EMPLOYEES

The Administrator will be authorized to appoint, under Civil Service laws, rules and regulations, such additional employees as may be necessary. Employees of the Medical Service as at present constituted, other than those previously mentioned, will receive original appointments to the department in their present Civil Service status on certification of satisfactory service by the manager of the hospital, home or center where such person is at present employed. The annual salary range for hospital attendants will be $1,572 minimum to $1,902 maximum.

SPECIAL MEDICAL ADVISORY GROUP

The Administrator will be required to establish a special medical advisory group composed of members of the medical and allied scientific professions, nominated by the Chief Medical Director. The duties of this group will be to advise the Administrator, through the Chief Medical Director, and the Chief Medical Director direct, relative to the care and treatment of disabled veterans and relative to other matters pertinent to the Department of Medicine and Surgery. The group will conduct regular calendar quarterly meetings, and the number, terms of service, compensation and allowances to members of the group will be in accord with existing laws and regulations.

ATTENDANCE AT MEETINGS

The Chief Medical Director will be authorized to detail designated personnel to attend meetings of associations for the promotion of medical and related sciences and to pay their expenses. Among others, the Deputy Medical Director, the eight Assistant Medical Directors and the physicians, dentists and nurses appointed under the

authority contained in section 4 may be so designated.

POSTGRADUATE INSTRUCTION

The Administrator will also be authorized to afford educational opportunities to the personnel referred to in the preceding paragraph by detailing them to schools of the Army, Navy and Public Health Service and to civil institutions of learning for the purpose of increasing the professional knowledge or technical training of the personnel of the department. Such details may not be for a period in excess of ninety days in a year, will be subject to the consent of the authorities of the institutions and may not exceed 5 per cent of the personnel of the department at any one time. Tuition, transportation and educational fees of personnel so detailed will be paid. If any person authorized to attend any such course of training voluntarily leaves the service within two years after the completion of the course, he will be required to reimburse the Veterans Administration for the expenses incurred.

EMPLOYMENT ON PART-TIME BASIS

On the recommendation of the Chief Medical Director, the Administrator may employ, without regard to the Classification Act of 1923, physicians, dentists and nurses on a temporary full-time, part-time or fee basis. Dietitians, social workers, librarians and other professional, clerical, technical and unskilled personnel may be employed on a temporary full-time or part-time basis at such rates of pay as the Administrator may prescribe. No temporary full-time appointment may be made for a period in excess of ninety days.

RESIDENCIES

The Administrator will be authorized to establish residences, to appoint qualified persons to such positions with regard to Civil Service or classification laws, rules or regulations and may prescribe the conditions of such employment, including necessary training, and the customary amount and terms of pay during the period of such employment and training.

RULES AND REGULATIONS

The Chief Medical Director with the approval of the Administrator, unless specifically otherwise provided, will be authorized to promulgate all regulations necessary to the administration of the Department of Medicine and Surgery and consistent with existing law. Such regulations will include those relating to travel, transportation of household goods and effects, and deductions from pay for quarters and subsistence and to the custody, use and preservation of records, papers and property of the Department of Medicine and Surgery.

Space for Scientific Exhibit at 1946 A.M.A. Session Now Available

The various sections of the Scientific Assembly of the American Medical Association have appointed the following representatives to the Scientific Exhibit to assist and advise in the procurement of exhibits for the San Francisco session, July 1 to 5:

Practice of Medicine—Dr. Thomas C. Garrett, 3803 Oak Road, Germantown, Philadelphia.

Surgery, General and Abdominal—Dr. Warren H. Cole, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12.

Obstetrics and Gynecology—Dr. Frederick H. Falls, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12.

Ophthalmology—Dr. Georgiana D. Theobald, 120 Medical Arts Building, Oak Park, Ill.

Laryngology, Otology and Rhinology—Dr. Paul H. Holinger, 700 North Michigan Avenue, Chicago 11.

Pediatrics—Dr. W. Ambrose McGee, 1601 Monument Avenue, Richmond, Va.

Experimental Medicine and Therapeutics—Dr. Robert W. Wilkins, Evans Memorial Hospital, 65 East Newton Street, Boston.

Pathology and Physiology—Dr. Frank W. Konzelmann, Atlantic City Hospital, Atlantic City, N. J.

Nervous and Mental Diseases—Dr. F. P. Moersch, Mayo Clinic, Rochester, Minn.

Dermatology and Syphilology—Dr. Hamilton Montgomery, 102 Second Avenue S.W., Rochester, Minn.

Preventive and Industrial Medicine and Public Health—Dr. Paul A. Davis, 1436 Delia Avenue, Akron 2, Ohio.

Urology—Dr. John H. Morrissey, 40 East Sixty-First Street, New York.

Orthopedic Surgery—Dr. David M. Bosworth, 742 Park Avenue, New York 21.

Gastro-Enterology and Proctology—Dr. Grant H. Laing, 104 South Michigan Avenue, Chicago.

Radiology—Dr. S. W. Donaldson, 326 North Ingalls Street, Ann Arbor, Mich.

Anesthesiology—Dr. Urban H. Eversole, 605 Commonwealth Avenue, Boston.

General Practice—Dr. Wingate M. Johnson, 402 North Liberty Street, Winston-Salem, N. C.

Application blanks for space in the Scientific Exhibit may be obtained from the Section Representatives or from the Director, Scientific Exhibit, American Medical Association, 535 North Dearborn Street, Chicago 10.

Dr. Bertrand E. Lowenstein, instructor in the Department of Physiology of Yale University School of Medicine, has joined the Division of Research at the Cleveland Clinic. He will carry on genito-urinary investigations under the terms of the Packard-Endowment gift.

VETERANS' INQUIRY DEPARTMENT

Ohio Openings and Locations Sought by Returning Medical Officers; Opportunities Available Listed

THE purpose of this department is to provide space without cost to Ohio veteran physicians for the publication of inquiries they may wish to make concerning an assistantship or residency, a partnership or space in an office, locations and purchase of a practice, purchase of equipment, etc.

The new feature also offers an opportunity for physicians who desire to dispose of their practice or institutions and agencies needing staff physicians to publicize this information for the benefit of service men.

The feature will appear monthly as long as there seems to be a need for it. The regulations governing it are: (1) The veteran submitting the inquiry must be an Ohio physician, i.e., one who was in practice in Ohio when he entered the service or was a native of Ohio but still in training when he entered in the service. (2) Inquiries should not exceed 35 words. (3) Copy must be submitted by the 20th day of the month preceding date of publication. (4) Unless otherwise specified, each inquiry will be carried in two consecutive issues of *The Journal* but no oftener. (5) *The Journal* reserves the right to reject or edit copy submitted; also, to eliminate the new department when and if conditions warrant. (6) Inquiries should be accompanied by full name, forwarding address and identifying data.

OPPORTUNITIES SOUGHT

PEDIATRICIAN: Navy medical officer, aged 33, graduate of Ohio State University College of Medicine, trained in pediatrics, interested in pediatrics practice—preferably with group clinic. V.I.D. No. 1, care of Ohio State Medical Journal.

GENERAL SURGERY: Discharged Army medical officer, age 35, graduate of Northwestern University Medical School, surgical residency in approved Ohio hospital, seeking general surgical practice in Ohio or associateship or assistantship with man in practice. V.I.D. No. 2, care of Ohio State Medical Journal.

OTOLARYNGOLOGY TRAINING: Training in Otolaryngology through residency or assistantship sought by Army medical officer to be separated from service soon; age 32; graduate of Ohio State University College of Medicine. V.I.D. No. 3, care of Ohio State Medical Journal.

OBSTETRICAL TRAINING: Discharged medical officer desires assistantship or short residency in obstetrics and gynecological surgery or general surgery for period of month, six weeks or two months; age 48; graduate of St. Louis University School of Medicine. V.I.D. No. 4, care of Ohio State Medical Journal.

SURGICAL ASSISTANTSHIP: Wanted by veteran, age 33; six years surgical training including year of thoracic surgery; four years of Army surgery in states and overseas. Available after January 2. Ohio license. V.I.D. No. 5, care of Ohio State Medical Journal.

SURGICAL PRACTICE: Discharged medical officer, age 32, graduate of Ohio State University College of Medicine and residency in surgery, University Hospitals, Minneapolis, desires surgical practice. V.I.D., No. 6, care of Ohio State Medical Journal.

EQUIPMENT NEEDED: Returning medical officer desires to purchase an Ear, Nose and Throat Unit, new, or second hand if in good condition. V.I.D., No. 7, care of Ohio State Medical Journal.

PEDIATRICS OR GENERAL PRACTICE: Practice in pediatrics or general practice sought by discharged Army medical officer, 45 years of age, diplomate of American Board of Pediatrics. Willing to invest. Available immediately. V. I. D. No. 8, care of Ohio State Medical Journal.

LOCUM TENENS OR ASSISTANTSHIP: Wanted for eight months by discharged flight surgeon who will begin ENT postgraduate course Sept. 1; O.S.U. '37; aged 32; experienced in industrial surgical practice. V.I.D. No. 9, care of Ohio State Medical Journal.

SURGICAL RESIDENCY WANTED: By returning medical officer, age 46, with 15 years general practice and surgery; three years assistantship to general surgeon; 20 months in general surgery in Army overseas. Available after January 1. V.I.D. No. 10, care of Ohio State Medical Journal.

PRACTICE WANTED: Veteran will buy practice of retiring or deceased physician, small city preferred. Ten years' practice before entering service. V.I.D. No. 11, care of Ohio State Medical Journal.

INDUSTRIAL AND INSURANCE POSITION WANTED: By discharged Army medical officer. Ten years in general practice. Over three years in service, mostly spent as administrative head of installation doing large number of physical examinations. Age 44. V.I.D. No. 12, care of Ohio State Medical Journal.

OPHTHALMOLOGY TRAINING SOUGHT: Training in ophthalmology through residency or assistantship wanted by discharged Army medical officer; ten months' eye work in Army; capable refractionist. Age 34. Graduate of Ohio State University College of Medicine. V.I.D. No. 13, care of Ohio State Medical Journal.

OPPORTUNITIES OFFERED

GENERAL PRACTICE: Opportunity for general practice in town of 1,000 in Northwestern Ohio. Only one other physician. Home and office space available. One of Ohio's best agricultural areas and good marketing section. Write W. L. G., care of Ohio State Medical Journal.

STUDENT HEALTH SERVICE: Opening at Ohio University, Athens, in Student Health Service on trial basis, if desirable, with view to permanent arrangement later. Student enrollment about 2,000. Well-organized service, with small hospital and X-ray equipment. Young medical graduate preferred, but will consider others. Write or see Dr. E. H. Hudson, director, Student Health Service, Ohio University, Athens; telephone 24532.

GENERAL PRACTICE AVAILABLE: Physician wishing to retire wants to dispose of practice to returning veteran. Located in Wilmington, Clinton County, excellent farming community; good roads. Equipment includes modern furniture, large supply of drugs, supplies and instruments and library. Office rent reasonable and equipment and practice priced to sell immediately. R. H. Vance, M.D., 114 East Locust Street, Wilmington.

PLACE FOR GENERAL PRACTITIONER: Civic Association of Alger, Hardin County, population of 857, sponsoring project to secure physician for area. Good farming district and modern improvements. Good opportunity for

energetic doctor. Communicate with Mr. Glenn Hanson, president, Alger Civic Association.

INDUSTRIAL POSITION: Desirable position on medical staff of large rubber company; good salary. F.T.R., care of Ohio State Medical Journal.

INDUSTRIAL COMMISSION: Openings available in Medical Section, Ohio Industrial Commission. Consult Dr. Robert André, chief supervisor, Medical Section, State Office Bldg., Columbus.

PRACTICE AND OFFICE FOR SALE: Practice in community of 2,000, unopposed; modern six-room recently constructed brick office building for sale or rent. Combined industrial and rural practice. H.B.K., care of Ohio State Medical Journal.

PARTNERSHIP: Good location for young M.D. Will consider partnership, nothing to sell. Five-room apartment above office available for living quarters. Contact Dr. A. B. Martin, Blanchester, Ohio.

EMPLOYMENT OPPORTUNITIES: For physicians, good salary, institution for mentally deficient. Indiana license necessary. Write or wire Fort Wayne School, Fort Wayne 1, Indiana.

ASSISTANT DIVISION CHIEF: Position for physician as Assistant Chief, Division of Child Hygiene, Ohio Department of Health, available. Salary $4,400 to $4,800. Must be graduate of approved medical school, one year's internship and at least one year's graduate training, plus one year of training or experience in clinical pediatrics. Experience in maternal and child health desirable. Must be licensed in Ohio or eligible for licensure. Apply, Chief of Division of Child Hygiene, Ohio Department of Health, State Departments Building, Columbus 15.

STATE HOSPITAL STAFF OPENINGS: Staff physicians for various institutions serving the mentally ill, mentally defective and epileptic needed. Physicians who have had some psychiatric training or experience preferred but can offer positions to doctors who may be interested in becoming acquainted with the specialty. Two positions of special importance now open are: Superintendency, Youngstown Receiving Hospital (especially attractive for young physician with residency in psychiatry) and Clinical Directorship, Gallipolis State Institute (fine opportunity for man who has had neuropsychiatric training to become acquainted with those neurological conditions that cause epilepsy in addition to a chance to be a specialist in the field of true epilepsy). Consult Dr. Frank F. Tallman, Ohio Commissioner of Mental Hygiene, State Departments Building, Columbus 15.

PUBLIC HEALTH OFFICERS NEEDED: Several counties in Ohio in need of full-time health commissioners. Those with training and experience, or interested in public health work, may obtain complete details from Dr. Roger Heering, Ohio Director of Health, State Departments Building, Columbus 15.

AREAS NEEDING PHYSICIANS: A list of Ohio areas badly in need of physicians, primarily for general practice—communities which were not the residence of any medical officer prior to the war—will be furnished on inquiry by the Headquarters Office, Ohio State Medical Association, Columbus.

PRACTICE FOR SALE: Active practice in county seat, Northwestern Ohio, for sale. Average of 100 obstetrical cases a year. Most physicians in upper age group. Railroad and insurance appointments available. Introduction and help for limited time offered. Equipment includes X-ray, diathermy, modern furniture, complete tonsillectomy instruments, large supply of drugs and supplies. Complete records of patients on file. No real estate for sale. Nominal rent. Hospitals nearby. Thriving industries and fine agriculture community, with paved roads. Estimated price, without complete inventory, $4,000 to $5,000. Box X, Ohio State Medical Journal.

PRACTICE FOR SALE: Active practice in a community of 3,000, North Central Ohio. Large amount of industrial work in addition to regular practice. Equipment includes new X-ray, diathermy, modern furniture, drugs and supplies. No real estate for sale. Moderate rent. Estimated price $7,500, cash or terms. Will introduce for a short time. Write R.J.S., care of Ohio State Medical Journal.

TUBERCULOSIS HOSPITAL OPENING: Resident physician needed in this institution doing intensive collapse therapy, including surgery. Good opening for man who desires to enter this field of medicine. District Tuberculosis Hospital, Lima; H. H. Brueckner, M.D., superintendent.

Army Offers Refresher Training For Doctors Leaving the Service

Refresher training of 12 weeks' duration will be given Army doctors leaving the service who desire to brush up on latest developments in fields of medicine, surgery, or neuropsychiatry in which they may not have been actively practicing during the past year, Major General Norman T. Kirk, Surgeon General of the Army, has announced.

This training will be given at Army hospitals until June 30, 1946. Reserve Corps, National Guard, and AUS Medical Corps officers who are to be separated will be eligible.

The election of the period of refresher training is entirely voluntary, and applications may be made through channels to the Surgeon General in the case of medical officers assigned to the Army Service Forces, Army Ground Forces and Army Air Forces. Medical officers returning from overseas may make application for refresher training from the Reception Stations or Separation Centers through the ASF Liaison Officer directly to the Surgeon General. **It is pointed out that medical officers can not be recalled to active duty from terminal leave for the purpose of accepting a professional assignment for refresher training.**

The Surgeon General emphasizes the fact that the refresher training is accomplished by a 12-week temporary duty assignment in the professional field of interest at an Army hospital without per diem. Such an assignment will afford the medical officer a period of clinical work under supervision, and opportunities for collateral study of recent advances in medicine, surgery, and neuropsychiatry.

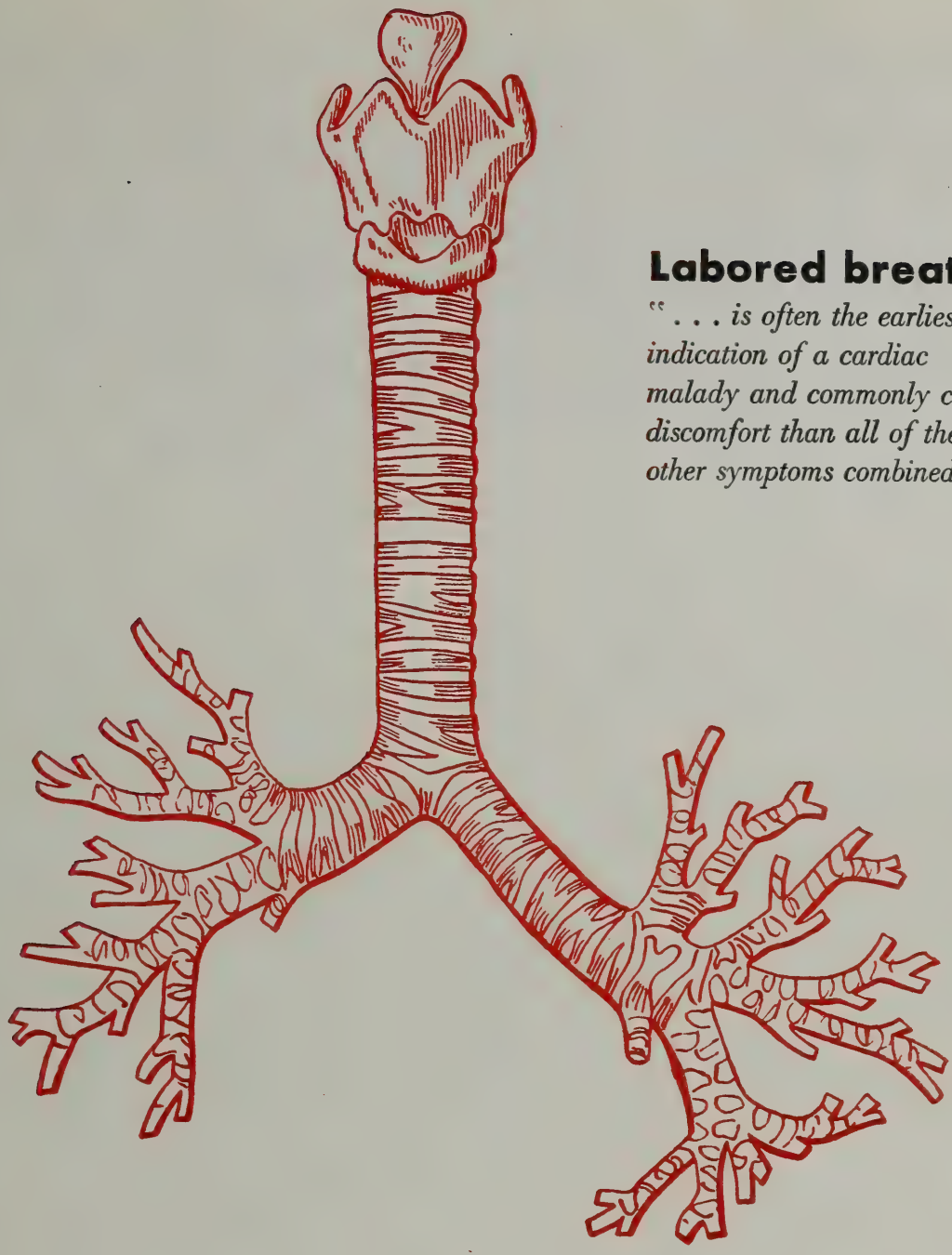
General Lull New Associate General Manager of A.M.A.

The appointment of Maj. Gen. George F. Lull, Deputy Surgeon General of the Army, as Associate General Manager of the American Medical Association has been announced by the Board of Trustees.

The appointment was effective January 1, the date of the General's retirement from active Army service after 33 years as a medical officer.

General Lull commanded a base hospital in France during the first World War and has served terms as chief of laboratory service and director of laboratories at Walter Reed General Hospital; professor of bacteriology at the Army Medical College, and medical adviser to the Governor General of the Philippines.

The Distinguished Service Medal was awarded to General Lull for his work as Chief of the Personnel Service in the Surgeon General's Office from 1940 to 1943. Appointed Deputy Surgeon General in May, 1943, he acted as director of personnel and chief of the statistical division.



Labored breathing...

"... is often the earliest indication of a cardiac malady and commonly causes more discomfort than all of the other symptoms combined."[1]

AMINOPHYLLIN-SEARLE, by relaxing the bronchial musculature, encouraging resumption of a more normal type of respiration, reduces the load placed on the heart and helps prevent further damage.

Aminophyllin-Searle is indicated in paroxysmal dyspnea, Cheyne-Stokes respiration, bronchial asthma (particularly in epinephrine-fast cases) and in selected cardiac cases.

Aminophyllin-Searle contains at least 80% anhydrous theophyllin. G. D. Searle & Co., Chicago 80, Illinois.

ACCEPTED AMERICAN MEDICAL ASSN

1. Harrison, T. R.: Cardiac Dyspnea, Western J. Surg., 52:407 (Oct.) 1944.

SEARLE *Research in the Service of Medicine*

List of Ohio Physicians Released From Military Service Growing; 807 Reported Discharged Since V-E Day

COMPILATION of reports received by *The Journal* and the Ohio State Medical Association during the past month shows that 176 additional Ohio physicians have been discharged from military service or are on terminal leave pending final discharge.

As of January 23, a total of 807 Ohio physicians have been released from active military duty since V-E Day.

In order that The Journal may publish monthly as complete and accurate a list as possible of Ohio medical officers separated from the service, the active cooperation of medical officers themselves, their families and County Medical Society officers, in transmitting such information to the Columbus office of the Ohio State Medical Association, is solicited. Please send the information in promptly, so new names can be added to the list immediately.

Moreover, medical officers are again reminded that the Columbus Office is prepared to supply them with helpful information regarding postgraduate education opportunities and data on opportunities for establishing a practice.

In the following tabulation, the city in which the medical officer resided or practiced when he entered the service is given in most instances. If the physician, after separation, has changed location and this information is known, the place of relocation also is indicated. The rank shown is based on the latest information on file which, of course, may not be up to date in a few cases:

Name	City	Rank
Albert, Irwin C.	Cincinnati	Major, A.U.S.
Alberts, Edward	Cincinnati	Major, A.U.S.
Amstutz, Hubert M.	Lancaster	Lt. Col., A.U.S.
Anderson, John G.	Lynchburg	Major, A.U.S.
Anzinger, Frank W.	Springfield	Capt., A.U.S.
Ash, Clarence E.	Columbus (formerly of Cincinnati)	Capt., A.U.S.
Baker, Calvin L.	E. Hartford, Conn. (formerly of Cridersville)	Major, A.U.S.
Behm, Alton W.	Chardon	Capt., A.U.S.
Bell, Clarence H.	Mansfield	Capt., A.U.S.
Bell, Joseph J.	Cincinnati	Major, A.U.S.
Berg, Theodore	Elyria	Major, A.U.S.
Bill, Herbert E.	Cleveland	Lt. Col., A.U.S.
Birkbeck, Norman J.	Dayton	Comdr., U.S.N.R.
Boice, Robert R.	Pomeroy	Major, A.U.S.
Borer, R. J.	Toledo	Lt. Col., A.U.S.
Braden, Spencer	Cleveland	Lt. Col., A.U.S.
Brett, John D.	Cleveland	Capt., A.U.S.
Burkhardt, Stanley L.	Steubenville	Lt., U.S.N.R.
Cassaday, Charles E.	Columbus	Capt., A.U.S.
Clippinger, Conrad K.	Covington (formerly of Dayton)	Capt., A.U.S.
Clodfelter, H. M.	Columbus	Comdr., U.S.N.R.
Cohen, Jacob R.	Steubenville	Capt., A.U.S.
Crawford, Robert R.	Mansfield	Comdr., U.S.N.R.
Crumley, Harold M.	Chillicothe	Lt. Col., A.U.S.
Danahy, John C.	Cincinnati	Comdr., U.S.N.R.
Davis, Mel A.	Painesville	Lt. Comdr., U.S.N.R.
Domall, E. E.	Ann Arbor, Michigan (formerly of Toledo)	Lt., U.S.N.R.
Dowling, James R.	Massillon	Major, A.U.S.
Duckwall, Henry M.	Dayton	Capt., A.U.S.
Earley, Daniel	Cincinnati	Major, A.U.S.
Eiser, Joseph	Toledo	Major, A.U.S.
Englerth, Fredk. L.	Dayton	Major, A.U.S.
Faircloth, William B.	Zanesville	Lt. Comdr., U.S.N.R.
Falk, John H.	Cincinnati	Lt. Col., A.U.S.
Falor, William H.	Akron	Major, A.U.S.
Fargo, Warren C.	Cleveland	Col., A.U.S.
Fatum, Oscar J.	Van Wert	Capt., A.U.S.
Feiman, Daniel T.	Cleveland	Comdr., U.S.N.R.
Fleming, John G.	Cincinnati	Lt. Comdr., U.S.N.R.
Fowler, Murray N.	Mansfield	Major, A.U.S.
Fox, Dale E.	Cincinnati	Major, A.U.S.
Frederick, Victor R.	South Charleston	Capt., A.U.S.
Freed, Alexander N.	Cleveland	Capt., A.U.S.
Gerlinger, Theodore V.	Columbus (formerly of Willard)	Major, A.U.S.
Gerson, Samuel K.	St. Louis, Missouri (formerly of Lancaster)	Capt., A.U.S.
Giber, Philip B.	Girard	Major, A.U.S.
Goldcamp, J. S.	Youngstown	Major, A.U.S.
Graf, Douglas P.	Cincinnati	Capt., A.U.S.
Gregg, Walter K.	Dayton	Lt. Col., A.U.S.
Grove, Paul C.	Newark	Capt., A.U.S.
Hahn, Paul D.	New Philadelphia (formerly of Warsaw)	Capt., A.U.S.
Halfhill, James W., Jr.	Lima	Major, A.U.S.
Hamilton, G. W.	Akron	Capt., A.U.S.
Hansen, Paul G.	Cleveland	Col., A.U.S.
Harris, Leonard H.	Elyria	Lt., U.S.N.R.
Hartman, Joyce I.	Cleveland	Comdr., U.S.N.R.
Hedges, Jasper M.	Columbus	Capt., A.U.S.
Herzberg, Mortimer, Jr.	Cincinnati	Capt., A.U.S.
Heyde, Edward C.	Wooster	Capt., A.U.S.
Hise, Fred R.	Canton	Lt. Comdr., U.S.N.R.
Hochwalt, William R.	Dayton	Lt. Col., A.U.S.
Hoecker, Robert H.	Mt. Vernon	Capt., A.U.S.
Hoerner, J. K.	Dayton	Lt. Col., A.U.S.
Holmes, Joseph H.	Fremont	Capt., A.U.S.
Huesman, A. J.	Cincinnati	Lt. Comdr., U.S.N.R.
Hunsche, Charles W.	Cincinnati	Major, A.U.S.
Jackson, Elmer L.	Shelby	Lt., U.S.N.R.
Jennings, William P.	Cincinnati	Major, A.U.S.
Jobe, Charles H.	Cleveland	Capt., A.U.S.
Johnson, Clifford	Mt. Vernon	1st Lt., A.U.S.
Johnson, Walter A.	Rossford	Capt., A.U.S.
Jones, John L.	Medina	Major, A.U.S.
Jones, S. R.	Cincinnati	Lt. Comdr., U.S.N.R.
Kalker, John R.	Cleveland	Major, A.U.S.
Keller, Bayard M.	Cuyahoga Falls	Major, A.U.S.
Kellogg, Paul E.	Ashland	Lt. Comdr., U.S.N.R.
Kennedy, Roscoe J.	Cleveland	Capt., U.S.N.R.
Kidd, Robert A.	Columbus	Lt. Comdr., U.S.N.R.
King, Arthur G.	Cincinnati	Lt. Col., A.U.S.
Kingsley, Glenn E.	Lorain	Major, A.U.S.
Kirkbride, Willis J.	Toledo	1st Lt., A.U.S.
Kolb, George C.	Cincinnati	Major, A.U.S.
Krause, George R.	Cleveland	Lt. Col., A.U.S.
Kyman, Seymour	Cleveland	1st Lt., A.U.S.
Langan, Paul C.	Akron	Lt. Col., A.U.S.
Lapp, Henry T.	Wilmington (formerly of Utica)	Lt. Col., A.U.S.
Lawton, O. M.	Canfield	Capt., U.S.N.R.
Lawyer, Frank G.	Cambridge	Capt., A.U.S.
Lederer, Henry D.	Cincinnati	Major, A.U.S.
Lester, Louis J.	Cleveland	Capt., A.U.S.
Lewis, David R.	Grove City	Capt., A.U.S.
Leyrer, Henry G.	Sandusky (formerly of Wadsworth)	Lt. Comdr., U.S.N.R.
Loomis, E. C.	Dayton	Major, A.U.S.
Mack, James R.	Cincinnati	Capt., A.U.S.
Mannhardt, Herman W.	Bowling Green	Lt. Comdr., U.S.N.R.
Marshall, M. K.	Findlay	Capt., A.U.S.
Mastropaolo, A. J.	Batavia	1st Lt., A.U.S.
Mayfield, Frank H.	Cincinnati	Lt. Col., A.U.S.
McCormick, James E.	Zanesville	Major, A.U.S.
Mendelsohn, H. J.	Cleveland	Capt., A.U.S.
Meyer, Jerome H.	Lakewood	Capt., A.U.S.
Michael, Nicholas	Columbus	Lt. Col., A.U.S.
Mielcarek, Paul A.	Cleveland	Lt. Col., A.U.S.
Mikes, Frank L.	Cleveland	Lt. (j.g.), U.S.N.R.
Miles, R. Keith	London (formerly of Thompson)	Capt., A.U.S.
Miller, Thomas E.	Ironton	Capt., A.U.S.
Mollin, Edwin L.	Akron	Capt., A.U.S.
Morse, Dan G.	Columbus	Major, A.U.S.
Myers, Cyril E.	Akron	Major, A.U.S.
Myers, Stanley A.	Youngstown	Comdr., U.S.N.R.
Nealon, James K.	Newark	Major, A.U.S.
Needham, Leslie E.	Conneaut	Major, A.U.S.
Northrup, Spencer	Toledo	Lt. Comdr., U.S.N.R.
Nusbaum, W. D.	Lancaster	Lt. Comdr., U.S.N.R.
Orosz, Ernest C.	Cleveland	Capt., A.U.S.
Parry, T. L.	Akron	Major, A.U.S.

The Hand of Time and

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MAPHARSEN, now entering its thirteenth year of active clinical use, has assumed a leading role among arsenical antisyphilitics. More than 150,000,000 doses of MAPHARSEN have been used clinically during the past five years with a minimum of reaction and maximum of therapeutic effect.

United States Navy records[1] consistently show the relatively low toxicity of MAPHARSEN. Over the ten-year period, 1935-1944 inclusive, Navy reports indicate one fatality for every 167,826 injections of MAPHARSEN. Compare this to the Navy reports on neoarsphenamine for the same period which show one fatality in every 28,463 injections.

MAPHARSEN (meta-amino-para-hydroxyphenyl arsine oxide (arsenoxide) hydrochloride) offers another great advantage in that its solution does not become more toxic on standing, nor does agitation or exposure to air increase its toxicity. Stokes[2] states that no loss of efficacy or increase in toxicity result when the solution is allowed to stand for several hours exposed to the air. Therefore, haste need not be made in preparation of the solution for injection.

[1] U.S. Nav. M. Bull. 45:783, 1945, and previous annual Navy reports.

[2] Stokes, J.H., Beerman, H. and Ingraham, N.R.; Modern Clinical Syphilology, ed. 3, Philadelphia, W.B. Saunders Company, 1945, pp. 359, 300.



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Name	City	Rank
Peelle, E. D.	Wilmington	Major, A.U.S.
Pocotte, Robert W.	Toledo	Capt., A.U.S.
Price, Fredk. F.	Stony Ridge	Capt., A.U.S.
Rayman, Lawrence	Toledo	Capt., A.U.S.
Recroft, E. W.	Cleveland	Capt., A.U.S.
Rehm, Ernest D.	Toledo	Capt., A.U.S.
Rian, Carlos D.	Massillon	Capt., A.U.S.
Rodabaugh, Franklin	Toledo	Major, A.U.S.
Rohrbaugh, John R.	Massillon	Capt., A.U.S.
Rose, James E.	Sabina	Capt., A.U.S.
Ruppersburg, Anthony	Columbus	Lt. Col., A.U.S.
Sabin, Albert B.	Cincinnati	Lt. Col., A.U.S.
Santurello, Thomas D.	Columbus	Lt. Col., A.U.S.
Schroeder, Raymond H. (formerly of Quincy)	Dayton	Capt., A.U.S.
Schumacher, Arthur H.	Cleveland	Lt. Comdr., U.S.N.R.
Schweitzer, Julius P.	Lakewood	Capt., A.U.S.
Shagrin, Arthur	Cleveland	Capt., A.U.S.
Sheldon, Dean	Sandusky	Comdr., U.S.N.R.
Sherrer, Edward L.	Cleveland	Lt. Col., A.U.S.
Shulman, Leon	Steubenville	Major, A.U.S.
Silver, E. I.	Cleveland	Major, A.U.S.
Simpson, A. M.	Cleveland	Capt., A.U.S.
Smead, Robert L.	Toledo	Capt., A.U.S.
Smith, Trent W. (formerly of Cincinnati)	Columbus	Major, A.U.S.
Solomon, Walter M.	Cleveland	Lt. Col., A.U.S.
Sparks, Aubrey L.	Warren	Major, A.U.S.
Spencer, Newton C.	Toledo	Lt. Col., A.U.S.
Spisak, Edward A.	Cleveland	Lt., U.S.N.R.
Spragens, Fred E.	Antwerp	1st Lt., A.U.S.
Stager, Walter R.	Dover	Major, A.U.S.
Stephens, Vernon D.	Columbus	Major, A.U.S.
Stinson, W. V.	Dayton	Capt., A.U.S.
Stokien, Ernest D.	Cleveland	1st Lt., A.U.S.
Stout, Walter M.	Columbus	Major, A.U.S.
Swango, William R.	Ironton	Capt., A.U.S.
Teufel, William J.	Cleveland	1st Lt., A.U.S.
Thiessen, Norman W.	Lakewood	Lt. Col., A.U.S.
Thornton, John J.	Cleveland	Capt., A.U.S.
Tramont, Charles B.	Mt. Vernon	Capt., A.U.S.
Tsaloff, Nicholas M.	Akron	Major, A.U.S.
Ulicny, Harry P. (formerly of Toledo)	Fostoria	Major, A.U.S.
Venar, Yasha	Cleveland	Major, A.U.S.
Vokoun, Frank J.	Cleveland	Lt. Col., A.U.S.
Votypka, Edward A.	Cleveland	1st Lt., A.U.S.
Walker, Glenn H.	Woodville	Major, A.U.S.
Weiss, Leo	Toledo	1st Lt., A.U.S.
Weitz, Myron A.	Cleveland	Lt. Col., A.U.S.
Weller, L. W.	Youngstown	Major, A.U.S.
Wellmeier, Hugh	Piqua	Major, A.U.S.
Whitehead, R. N.	Bowling Green	Lt. Comdr., U.S.N.R.
Wiedemer, Hall S.	Columbus	Capt., A.U.S.
Wiessinger, Russell L.	Sidney	Capt., A.U.S.
Wilcox, Abbott Y.	Cincinnati	Major, A.U.S.
Wills, Benjamin F.	McArthur	Major, A.U.S.
Woldman, Edward	Cleveland	Lt. Col., A.U.S.
Wolpaw, Sidney E.	Cleveland	Major, A.U.S.
Wright, Robert N.	Wooster	Major, A.U.S.
Wynsen, Henry J.	Youngstown	Major, A.U.S.
Yordy, Paul L.	Dayton	Capt., U.S.N.R.
Zeichaml, C. E.	Cleveland	Lt. Col., A.U.S.

WIN PROMOTIONS

Name	City	Rank
Anderson, G. I.	Cleveland	Capt., A.U.S.
Jones, Charles F.	Toledo	Capt., A.U.S.
Kilpatrick, Elmer	Columbus	Major, A.U.S.
Kistner, Robert W.	Cincinnati	Capt., A.U.S.
Kuehn, Conrad A.	Gallipolis	Major, A.U.S.
Moore, Frank R.	Cincinnati	Lt., U.S.N.R.
Moorehead, James R.	Seville	Major, A.U.S.
Musgrave, Myrl D.	Cleveland	Capt., A.U.S.
Perry, William H.	Cleveland	Capt., U.S.N.R.
Peters, Eugene W.	Cleveland	Comdr., U.S.N.R.
Robishaw, Arthur W.	Elyria	Comdr., U.S.N.R.
Schoolfield, C. B.	Upper Sandusky	Major, A.U.S.
Smedal, E. A.	Mansfield	Major, A.U.S.
Thomas, M. P.	Cleveland	Lt. Comdr., U.S.N.R.
Tucker, Thomas W.	Cincinnati	Lt. Comdr., U.S.N.R.

Military News Notes

Members of the State Headquarters Office staff acknowledge with thanks the many fine letters received from returning medical officers expressing appreciation for the receipt of The Ohio State Medical Journal while they were in the service. It's a pleasure to remove your stencil from the military file and restore your name to the Ohio mailing list. And how's for "staying put" from now on?

Maj. Franklin D. Rodabaugh, Pandora, now on terminal leave, was presented with the Legion of Merit, Dec. 4, at Shanghai for "exceptionally meritorious conduct in the performance of outstanding services from 11 May, 1944 to 22 January, 1945". This period included his duty with Chinese troops during the Salween campaign and the Bubonic Plague epidemic near Tengchung, China.

* * *

Maj. James H. Harsha, Washington C. H., is assigned to the 385th Medical General Dispensary at Manila.

* * *

"This hospital is so loaded with patients and no E.E.N.T. specialists available to replace me, that I became soft and agreed to stay another few months to help dispose of them", writes Capt. W. H. Perry, M.C., U.S.N.R., Cleveland, from the U. S. Naval Hospital, Chelsea, Mass.

* * *

Maj. William L. Porter, Cincinnati, is at home recovering from the effects of a fractured spine received while in Japan.

* * *

Lt. Comdr. M. P. Thomas, Cleveland, is grateful for the experience offered by his recent assignment as chief of the Contagious and Tropical Disease Service of the U. S. Naval Hospital, San Diego. He previously had two years of foreign sea duty.

* * *

Capt. Curt Nemrow, Cleveland, is with the 216th General Hospital, Stuttgart, Germany.

* * *

Changes of address: Capt. Nathan R. Abrams, Cincinnati, Army and Navy Gen. Hosp., Hot Springs, Ark.; Capt. Harold C. Klein, Cleveland, 3107 Washington Blvd., Cleveland Heights; Capt. A. B. Schneider, Cleveland, Hq., PACUSA, APO 925, c/o PM, San Francisco; Capt. William Roach, Cincinnati, WDPC, Med. Br., Camp Chaffee, Ark.; Capt. Richard Schroder, Cincinnati, Crile Gen. Hosp., Cleveland; Lieut. Henry P. Koehler, Findlay, USS Mobile, c/o FPO, San Francisco; Maj. E. M. Kilpatrick, Columbus, Bushnell Gen. Hosp.,

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Cascara Petrogalar

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A USEFUL LAXATIVE—Cascara Petrogalar combines the mild stimulating action of cascara with the softening effect of homogenized mineral oil. Prompt, easy evacuation of soft, formed stools is assured without undue strain or discomfort. Especially useful in treating stubborn cases and in elderly persons, its pleasant, dependable action helps to restore "habit time" of bowel movement. CASCARA PETROGALAR—an aqueous suspension of Mineral Oil, 65%, with aqueous extract of Cascara Sagrada, 13.2%.

Supplied in 8 fl. oz. and pint bottles

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Brigham, Utah; Maj. Frederick S. Coombs, Youngstown, AAF Reg. Hosp., Chanute Field, Ill.; Capt. James S. Caldwell, Cincinnati, Reg. Hosp., AAF, Amarillo, Texas; Lt. Col. Charles S. Higley, Cleveland, AAF, Chanute Field, Ill.; Maj. Glenn H. Heller, Akron, Sta. Hosp., Biggs Field, El Paso, Texas; Lt. James H. Anderson, Sta. Hosp., Fort Bragg, N. C.

* * *

Col. Paul G. Hansen, North Olmsted, has been awarded the People's Hero Medal by the Chinese government. Now attached to a medical detachment in China, he has been in charge of hospitals in central and western China for the past two years. Some time ago he was awarded the Bronze Star Medal. Dr. Hansen entered the service April 22, 1940.

* * *

The Legion of Merit has been awarded Col. Johnson McGuire, Cincinnati, for outstanding service as medical consultant for the Fifth Service Command. "By reason of his unfailing tact, judgment and superior professional qualifications, Col. McGuire was, in a great measure, responsible for the outstanding quality of medical treatment by hospitals of the Fifth Service Command", the citation stated.

* * *

Now on terminal leave, Lt. Col. Charles U. Hauser, Cincinnati, and Lt. Col. Dorrence S James, Delaware, were recently promoted to their present rank.

Fourteen More Army Hospitals To Close by March 31

Fourteen additional Army general hospitals, three annexes to general hospitals and four convalescent hospitals will be closed by March 31, 1946, according to present Army Medical Department plans, Major General Norman T. Kirk, Surgeon General of the Army, has announced. In accordance with the Surgeon General's policy of releasing these hospitals as rapidly as the decrease in the patient load justifies, these units will be offered to the Veterans Administration or else reported to the Surplus Property Administration for disposal.

Out of a wartime peak of 65 general hospitals operated by the Army Medical Department, 20 have already been closed. In addition, out of a peak of 13 Army Services Forces convalescent hospitals, three have already been closed. The closing of these fourteen general hospitals, three annexes and four convalescent hospitals will result in a reduction of approximately 38,000 beds in general hospitals and 6,500 in convalescent hospitals.

After the evacuation of all transportable cases from overseas theaters there were approximately 121,400 patients in Army general and convalescent hospitals at the first of the year. It is estimated that there will be approximately 39,700 on June 1, 1946. The peak patient load in Army hospitals in the United States was reached in August, 1945, with a total census of 315,000.

There will be a lapse of 60 days between the dates on which the hospitals will be closed and the dates on which they will be declared surplus to the needs of the War Department, in order to allow time for handling transfer of property and other administrative details.

The following general hospitals will be released by February 28: Billings Gen. Hosp., Fort Benjamin Harrison, Indiana (will revert to station hospital status to serve the needs of Fort Benjamin Harrison); Camp Butner Gen. Hosp., Camp Butner, N. C.

The following are scheduled for closure by March 31: Camp Edwards Gen. Hosp., Camp Edwards, Mass. (will revert to station hospital status to serve the needs of Camp Edwards); Thomas M. England Gen. Hosp., Atlantic City, N.J.; McGuire Gen. Hosp., Richmond, Va.; Woodrow Wilson Gen. Hosp., Staunton, Va.; Northington Gen. Hosp., Tuscaloosa, Ala.; **Fletcher General Hospital, Cambridge, Ohio**; Nichols Gen. Hosp., Louisville, Ky.; Vaughan Gen. Hosp., Hines, Ill.; Camp Carson Gen. Hosp., Camp Carson, Colo.; Schick Gen. Hosp., Clinton, Iowa; McCloskey Gen. Hosp., Temple, Texas; and Birmingham Gen. Hosp., Van Nuys, Calif.

The following closures include the annexes only, not the general hospitals: Edgewood Annex to Mason Gen. Hosp., Brentwood, Long Island, N. Y.; Daniel Field Annex to Oliver Gen. Hosp., Augusta, Ga.; and Eastman Annex to Army and Navy Gen. Hosp., Hot Springs, Ark.

The following convalescent hospitals are scheduled for closure by March 31: Camp Edwards Conv. Hosp., Camp Edwards, Mass.; Fort Story Conv. Hosp., Virginia Beach, Va.; Camp Carson Conv. Hosp., Camp Carson, Colo.; and Mitchell Conv. Hosp., Camp Lockett, Calif.

Named Assistant Secretary

Dr. A. Ray Dawson, formerly a lieutenant colonel in the Medical Corps of the Army of the United States, has been appointed assistant to the Secretary of the Council on Industrial Health of the American Medical Association. He will be in charge of workmen's compensation and rehabilitation. Prior to his association with the reconditioning and rehabilitation program of the Army Air Forces, Dr. Dawson was affiliated with the Jefferson Standard Life Insurance Company, Greensboro, N. C., and served as medical officer in the U. S. Civil Service Commission, Washington, D. C. He graduated at the Medical College of Virginia, Richmond, in 1929.





The foundation is the thing!

Built on a *firm foundation,* the Leaning Tower of Pisa has withstood the centuries . . . so, too, health and vigor in infancy and the years ahead depend on a *firm foundation* of optimum nutrition. • BIOLAC, when supplemented with vitamin C, is a valuable infant food whose ample milk proteins constitute an adequate source of all essential amino acids . . . the indispensable *foundation stones* for sound tissues. • BIOLAC closely approximates mother's milk in safety, simplicity, and nutritional value.

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Quickly prepared . . . easily calculated: 1 fl. oz. Biolac to 1½ fl. oz. water per lb. of body weight.

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

DEAR MR. ANTHONY: WHAT WE WANT TO KNOW IS, CAN GENERAL PARRAN DO THAT TO US NOW EVEN BEFORE THE WAGNER-MURRAY-DINGELL BILL BECOMES A LAW?

ONE of the charges which has been made against the various proposals which have been offered by Senator Wagner and his fellow travelers to revolutionize medical and health services is that they would establish a medical dictatorship at Washington.

Those who made such a charge were immediately branded as reactionaries, viewers-with-alarm, falsifiers, etc., by the proponents of the so-called national health program.

In view of one recent development, it is our opinion that those who made the charges did not miss the mark too far.

We refer to the letter of December 10, 1945, over the signature of Dr. Thomas Parran, Surgeon General of the United States Public Health Service, Federal Security Agency, sent to "all officers of the Public Health Service" on the subject, "The National Health Program".

Dr. Parran's letter—mandate would be a better word for it—is indeed an interesting document. Following is the complete text. It becomes especially significant when one reads between the lines.

Enclosed is a copy of House Document No. 380, which is the full text of President Truman's message to the Congress on a national health program, a subject of the highest importance to every citizen. The message contains a comprehensive analysis of the health problems of the country and recommendations as to the pattern of legislation to deal with them.

It is a source of particular satisfaction to all of us who labor for the public health advancement that this should be the special subject of a Presidential message. For the first time we have the major elements of a national health policy officially stated in comprehensive terms. This has been a goal of all public health workers for many years, and the enunciation of such a policy by the Chief Executive gives the Public Health Service definite objectives for its future work.

On the same day as the message was delivered Senator Wagner introduced (for himself and Mr. Murray) S. 1606, and Representative Dingell introduced H. R. 4730, designed to implement the proposals of the President. In addition, several bills are pending in the Congress dealing with special phases of the President's legislative program. These include the hospital construction bills, the national mental health bills and the stream pollution bills, each of which would impose substantial additional responsibilities on the Public Health Service.

The appropriate executive agencies of the government have been specifically instructed by the President to assist in carrying out his legislative program as presented to the Congress on September 6. The President wrote to the administrator of the Federal Security Agency on October 4 requesting him "to take primary responsibility for legislative measures necessary to carry out the part of my message (Sept. 6, 1945) outlined in section 21 concerning a national health program to provide adequate medical care for all Americans and to protect them from financial loss and hardship resulting from illness and accident".

Every officer of the Public Health Service will wish to familiarize himself with the President's message and will be guided by its provisions when making any public statement likely to be interpreted as representing the official views of the Public Health Service.

THOMAS PARRAN, Surgeon General.

Let's examine the communication.

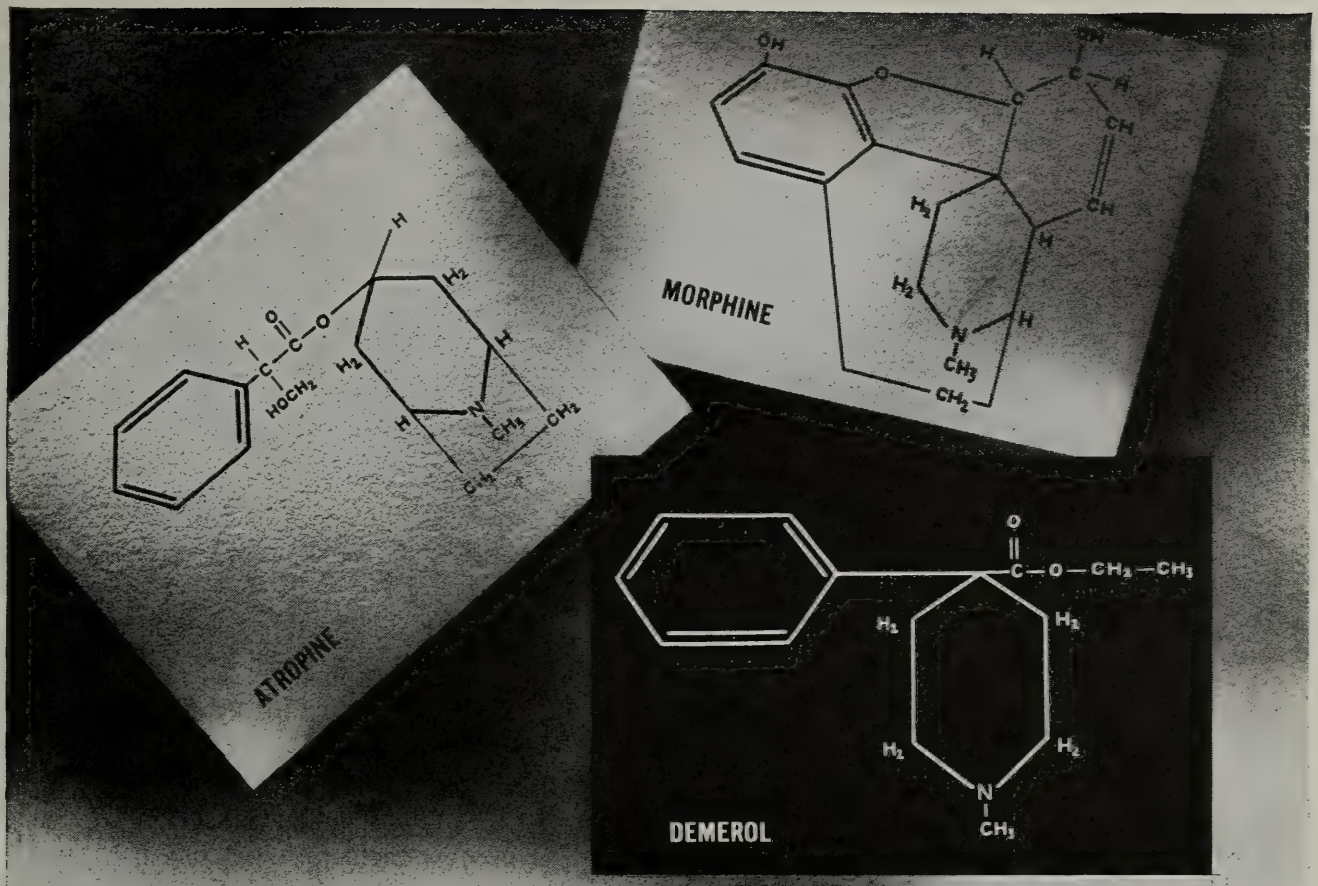
Paragraph No. 2 leaves little doubt as to how the officials of the Public Health Service feel about the Truman recommendations. The endorsement contained therein doesn't jibe with some of the hedging which Dr. Parran has done in the past on similar pieces of legislation. Now we know where he stands.

Paragraph No. 3 calls attention to specific pieces of proposed legislation. So, the conclusion must be drawn that these are the instruments which will bring about the "goal" which Dr. Parran mentioned in the preceding paragraph. The inference is that these are the "must" bills.

Paragraph No. 4 is especially interesting. Without offering any ifs or ands, it frankly infers that the Federal Security Agency is going to set up a lobby and is going to try to push the Truman program through the Congress.

But, the final paragraph is the pay-off. In it Dr. Parran just as much as says to the hired help: "Boys, if you know what's good for you, you'll get out and plug for this; at least you better not say anything against it."

We understand that some of the Ohio physicians, who got one of these letters by virtue of the fact that during the war they accepted reserve commissions in the U.S.P.H.S. when they affiliated with O.C.D. emergency hospital units, are burned up and have stated they will refuse to be muzzled or directed in their thinking by



Chemical Relationship and Pharmacodynamic Similarity

A NEW SYNTHETIC

ANALGESIC — Demerol's analgesic power ranks between morphine and codeine.

SPASMOLYTIC — Demerol's spasmolytic action is similar to that of atropine.

SEDATIVE — Demerol's sedative effect is mild, but usually sufficient to allay restlessness and induce sleep.

PRACTICALLY NO RISK OF RESPIRATORY DEPRESSION

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DEMEROL
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HYDROCHLORIDE

Brand of MEPERIDINE HYDROCHLORIDE
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Average adult dose: 100 mg. orally or intramuscularly.

HOW SUPPLIED — For oral use: Tablets of 50 mg., bottles of 25 and 100. For intramuscular injection: Ampuls of 2 cc. (100 mg.), boxes of 6 and 25, and vials of 30 cc. (50 mg. per 1 cc.).

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Brother Parran. No doubt there will be some resignations—maybe a flock of them.

With this little example before you, ponder for a minute over what could happen to all the doctors and all the patients of the country should the Surgeon General of the U.S.P.H. Service, whoever he may be, acquire the authority which would be delegated to him in event the newest version of the Wagner-Murray-Dingell Bill becomes a law.

SOME ACROBATICS WILL BE NEEDED

According to the press, President Truman is going in for a "drastic economy drive" in government spending, preliminary to the balancing of the Federal budget.

We hope he achieves his ultimate goal. But, it seems to us we have heard such words before but with little tangible results. Maybe the taxpayers will see that it's done this time.

Also, we're a bit confused as to how the President justifies his "economy" mandate and his speech advocating a national health program which would take a big chunk of the taxpayers' bankroll, we are sure, after Messrs. Wagner, Murray and Dingell get around to deciding just how they are going to touch Mr. John Q. Citizen for the wherewithall.

Looks as if Mr. Truman is going to have to be an acrobat or as one writer has observed, "he will need most aggressive support by public opinion, not only for cuts in present spending but also against a flood of proposals for new spending".

VIRGINIA THE KEY IN NEEDED ANTI-POLLUTION PROJECT

A year ago The Council of the Ohio State Medical Association took decisive action endorsing the Ohio River Valley Sanitation Compact and urged the medical societies of states directly concerned to do likewise in order to bring influence to bear on legislative bodies of all the interested states.

Since then great progress has been made. Enabling legislation has been passed in Ohio and in New York, Pennsylvania, West Virginia, Kentucky, Indiana and Illinois. Only Virginia delayed.

Now comes the unwelcomed news that the Virginia Advisory Legislative Council has recommended that Virginia decline to enter the compact. Virginia's assent is needed to make a beginning on this very necessary job of Ohio River purification.

It is to be hoped that Virginia will reconsider its action—and promptly. Virginia can not afford to stand by, blocking this vital project of cleaning up the Ohio and its tributaries upon whom millions of people must depend for their water supply. We urge the Virginia Medical Society to use its influence in this matter. It is a gigantic public health problem which must be solved and the medical profession in every state must be in the vanguard of those trying to find the solution.

HE WHO PAYS THE PIPER CALLS THE TUNE

We see by the papers that the Federal Social Security Board has threatened to withhold certain welfare funds from Ohio unless the state conforms to certain S.S.B. regulations with respect to personnel employed by Ohio for agencies which are receiving Federal-aid money. As we understand it, the U. S. Board is objecting to the hiring of provisional employees and the employment of some persons who do not meet the qualifications established by that board.

Well, says we with a chuckle, we've been saying for quite a spell that as long as Uncle Sam shells out the cash, he's going to run the show.

Wonder if the day will ever come when the executive and legislative branches of the Commonwealth of Ohio will have the courage and the wisdom to decide that Ohio, with all its wealth and ability, is able to finance and manage its own affairs of state, especially those services which affect the citizens of Ohio and no one else? The history books show that Ohio did it once. Why can't it do it again? Naturally, it can whenever the people of Ohio are ready to assume the responsibilities, financial and otherwise.

PORK BARREL POLITICS AND VETERANS' HOSPITALS

The outcome of the political battle now going on over whether the new Veterans Administration hospital promised this section of the country shall be located in Cincinnati, near the University of Cincinnati Medical Center, or near Fort Thomas, Kentucky, may reveal whether history will repeat itself or whether those who have been shouting promises to World War II veterans so loudly are actually sincere in what they say.

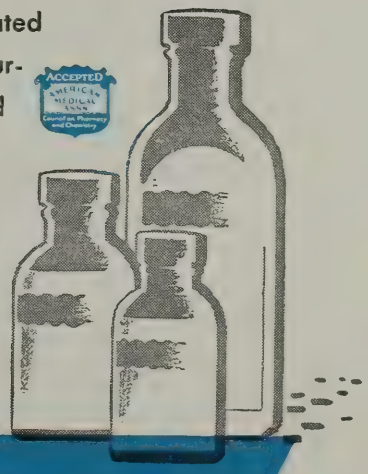
It is reported that a group of Kentucky Congressmen, who wield potent power at Washington, are leaving nothing undone to have the new institution erected on the Fort Thomas site. On the other hand, Ohio's Congressional delegation, supported by medical, hospital and civic groups in Cincinnati, are battling to have the hospital built in the Queen City. There it would be on a site near the University of Cincinnati where it can be serviced by the College of Medicine and draw on the medical profession of greater Cincinnati for consultation services.

If the welfare of disabled veterans is taken



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into consideration, the argument would dissolve over night. In fact, had this been done, there would have been no dispute. The Cincinnati site has everything to offer the disabled veteran and the Veterans Administration. The facilities of the University of Cincinnati Medical Center will not be available if the institution is built at Fort Thomas. The issue is clear-cut.

Politics and bureaucratic blundering created disgraceful situations within the Veterans Administration setup after World War I. Pork barrel politics will ruin the good intentions of Generals Bradley and Hawley of the Veterans Administration now, as evidenced by the Cincinnati-Fort Thomas squabble, unless something is done in a hurry. The "something" is going to have to be done by the people, including the veterans, by making known to members of the Congress that they expect first consideration to be given to the welfare of the disabled veterans.

President Truman, judging from his fireside radio chat, wants to know how the folks feel about things. We suggest, therefore, that you drop him a line about this. Maybe he can have a little talk with "Dear Alben" of Kentucky and get this matter straightened out.

VETERANS, FARMERS AND HEALTH PROGRAMS

According to the *National Legionnaire,* official publication of the American Legion, the Legion at its recent meeting in Chicago adopted a resolution (No. 196) which "requires opposition to the Wagner-Murray-Dingell Bill (socialized medicine".

At a recent meeting of the American Farm Bureau Federation, the following statement was adopted:

"One of rural America's most urgent problems is to provide a program to bring about better facilities in rural areas for hospitals, medical care and improved health. It will take the combined efforts of the medical profession and rural people to solve the problem.

"The solution must provide for comprehensive health education for well-trained doctors, dentists, nurses, technicians and laboratory scientists, as well as the establishment of Public Health Centers, hospitals and clinics accessible to all sections of rural America.

"The care of our former service men and women, of the mentally sick and the indigent and the control of communicable disease is a public obligation and should be supported from public taxation. In some communities, after careful surveys it may be found advisable to use Federal grants-in-aid to assist groups to erect and equip hospitals. These must be controlled by the local people themselves.

"We believe in the extension of voluntary group prepayment services on some type of an insurance plan that provides greater flexibility and would be more likely to succeed over a wide area than rigid uniform plans on a compulsory basis. We believe that a plan which will provide for prevention as well as curative measures and the right of the free choice of doctors should be zealously guarded."

These organizations no doubt are aware that there are real health problems which must be met but they are unwilling to support fantastic schemes allegedly designed to solve them. Interested as they are in the welfare of their respective memberships, both deserve the cooperation of the medical profession. The Legion wants disabled veterans to receive the best of medical care. This challenge must be met by physicians. The Farm Bureau wants better health programs for the rural citizens of America. This challenge also must be met by physicians, in conjunction with other groups, as there must be a realization that medical care alone will not produce better health for the rural population. These two large and important organizations, working with the medical profession, can go a long way toward setting up programs on a sound basis and with a minimum of political interference.

VOLUNTARY SYSTEM BETTER, P. D. EDITORIAL SAYS

An editorial which appeared in the *Cleveland Plain Dealer* on December 8 with respect to the Truman health proposal presents the viewpoint taken by the medical profession on this issue in a most convincing manner. Coming from a source which is not so close to the firing line as the medical profession is, the points set forth are of special significance.

We are reprinting the editorial in its entirety here and offer the suggestion that it be clipped by all readers of *The Journal* for future reference and citation:

VOLUNTARY SYSTEM BETTER

Reaction has been generally favorable to all but the compulsory insurance portion of the public health program proposed to Congress last month by President Truman.

The American public, including most of the medical profession, seems sufficiently convinced that the national health is a matter of government concern to approve Federal assistance to the states and local communities in the expansion of hospital facilities, maternal and child health centers and services and in the financing of medical research. It also seems to have been accepted as a logical move to expand the social security program sufficiently to provide financial assistance to individuals who lose time from work because of illness as such assistance is now given for unemployment resulting from other causes.

But neither the medical profession nor a majority of the public appears ready to accept compulsory health insurance. Despite the many arguments in its favor, we are inclined to believe the opposition to this proposal is well founded.

In the first place, wherever there is any possibility of reaching a desirable national goal by voluntary methods we should shy away from compulsion. President Truman asserted that the rate of growth of the voluntary hospitalization and medical group insurance programs was too

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Meets Doctors' Demands...Infants' Needs

• A complete milk diet that closely conforms to human milk... a nutritious food for infants that may be used either complemental to or entirely in place of human milk... well tolerated by both premature and full-term infants... a food that may be used from birth until the end of the bottle feeding period—without changing the formula... a diet that means a well-nourished, happy baby.

These are "end results" of the years of research back of Baker's Modified Milk.

What the attainment of these results means to doctors is attested by the steadily increasing use of Baker's Modified Milk, which is advertised only to the medical profession. More and more doctors are prescribing Baker's Modified Milk because they find Baker's produces desired results with less trouble in most cases of infant feeding... that no change in dilution is needed as the baby grows older (just increase the quantity of feeding)... and the possibility of errors—always present when formulas are prepared in the home—is avoided.

To prepare Baker's for feeding merely dilute it to the prescribed strength with water, previously boiled. Baker's is available in both powder and liquid forms. Formulas made from liquid Baker's are especially easy to prepare; in some cases, such as the lack of refrigeration in hot weather, or when traveling, the powder form is preferable.

Doctors and hospitals are invited to write for full information and samples.

• Baker's Modified Milk is made from tuberculin-tested cows' milk in which most of the fat has been replaced by animal and vegetable oils with the addition of lactose, dextrose, gelatin, iron ammonium citrate, vitamins A, B1 and D. Not less than 400 units of vitamin D per quart.

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slow, but we suspect the president overlooked the fact that this movement is now only a little more than 10 years old and that each year it has gained momentum. There is good reason to believe, as the American Medical Association asserts, that this momentum is now such that it will not be long before voluntary group health insurance will be available to the great majority of Americans.

It will be argued that the voluntary method will never include all Americans. But it must be remembered that neither will compulsory insurance ever be able to force all Americans to take care of themselves. And it must also be kept in mind that adequate hospital and medical care is not the whole answer to our health problems. In many sections of the country chronic ill health is due mostly to dietary conditions resulting from the condition of the soil or the ignorance of those who till it. Everywhere there are those who destroy their own health by habits over which medical science has no control.

In other words, while the objective of compulsory health insurance is entirely desirable, to achieve that objective the government would also have to regulate the family diet, compel scientific farming, control the nation's sex life, regulate the consumption of alcohol, tobacco and candy and compel everyone to see his doctor and his dentist regularly.

It is not necessary to observe that none of these compulsions are proper in a free society, that in such a society the objectives involved must be achieved, if at all, by education. Education is also, we believe, the better method of bringing about group health insurance.

STATUS OF HEALTH INSURANCE IN NEW YORK STATE

The Legislature of the State of New York, which meets annually, started its 1946 session on January 9. In its first legislative bulletin, the New York State Medical Society commented as follows:

"Governor Dewey in his message side-stepped the question in regard to a state health insurance plan, but under the Democratic Legislative Program it is stated, under 'Health Insurance', the following: 'We believe wholeheartedly in the principle of publicly administered health insurance, and urge prompt enactment of the Wagner-Murray-Dingell health bill and its implementation through the necessary state legislation. In the interim we will sponsor a state bill embodying the features of the Wagner-Murray-Dingell health bill.' It is thought, then, that there will not be a bill introduced until later in the session, if at all, under the Governor's Commission to Study Medical Care, of which Dr. MacLean is the chairman."

With this example before them, the physicians of Ohio might well decide now that it would be wise for them to take more than just a casual interest in the Spring primary elections in Ohio when nominees for the 1947 General Assembly will be elected. At the risk of repeating trite slogans, we would like to emphasize that no better persons can be elected to the next General Assembly than those who win at the primaries. What kind of candidates have filed in your county? Better find out—now.

National Conference on Medical Service Scheduled for Chicago, Feb. 10

The National Conference on Medical Service will be held February 10 at the Palmer House, Chicago. All Ohio physicians are invited to attend the conference which is resuming its annual status after a year's postponement.

The program for the day is as follows:

9:30 a.m. President's Address, "Medicine and the National Crisis", C. L. Palmer, M.D., Pittsburgh.

9:50 a.m. "What Labor Expects from Medicine", Walter Reuther, vice-president, United Auto Workers, CIO, Detroit.

10:20 a.m. "What the Farmer Expects from Medicine", J. S. Jones, secretary, Minnesota Farm Bureau Federation, and chairman, National Committee for Rural Health, St. Paul.

Discussion—Leonard W. Larson, M.D., member of committee on rural medical care, American Medical Association, Bismarck, N. D.

10:50 a.m. "What Industry Expects from Medicine", Howard Strong, secretary, Health Advisory Council, Chamber of Commerce of the United States, Washington, D. C.

11:20 a.m. Open Discussion.

12:00 noon. Luncheon.

1:45 p.m. "Medical Care of Veterans", Major General Paul R. Hawley, Acting Surgeon General, Veterans Administration, Washington, D.C.

2:15 p.m. "Aims and Purposes of Conference of Presidents and Other Officers of State Medical Societies", Andrew S. Brunk, M.D., president of "Conference of Presidents and Other Officers of State Medical Societies", Detroit.

2:30 p.m. Questions and Answers.

2:45 p.m. "What About Returning Medical Officers?" "Postgraduate Opportunities", Victor S. Johnson, M.D., secretary, Council on Medical Education and Hospitals, American Medical Association, Chicago.

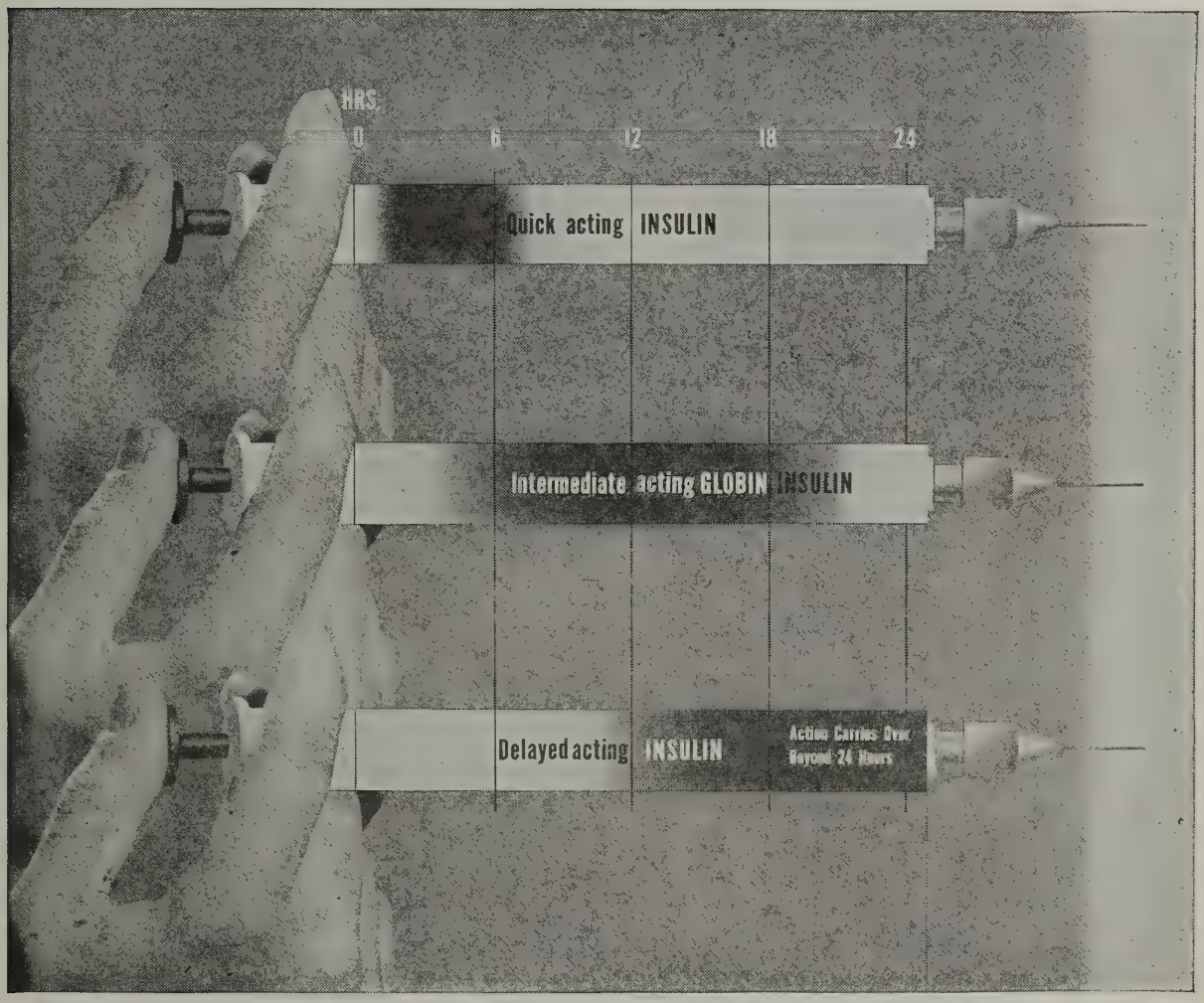
3:00 p.m. "Establishment of State Bureaus of Information", Mrs. M. Virginia Shuler, supervisor, Bureau of Information, American Medical Association, Chicago.

3:15 p.m. "Medical Legislation", J. W. Holloway, Jr., director, Bureau of Legal Medicine and Legislation, American Medical Association, Chicago.

3:30 p.m. "National Plan for Volunteer Prepayment Medical Care", Jay C. Ketchum, executive vice-president, Michigan Medical Service, Detroit.

Columbus—Public health in metropolitan Columbus was recently discussed on Columbus Town Meeting over WBNS, the topic being: "Is Our Health Program Sick?". Speakers included: Dr. Russel G. Means, Dr. John H. Mitchell and Dr. Nelson C. Dysart, city health commissioner.

Your 3 choices when treating diabetics...



WHEN A PHYSICIAN decides that a patient needs more than diet to control diabetes, he can now choose from three types of insulin. One is quick-acting and short-lived. Another is slow-acting and prolonged. Intermediate between these, is the third—the new 'Wellcome' Globin Insulin with Zinc. Its action begins with moderate promptness yet is sustained for sixteen or more hours—adequate to cover the period of maximum carbohydrate ingestion. By night, activity is sufficiently diminished to decrease the likelihood of nocturnal reactions. Physicians who consider the many advantages of this new third type of insulin now have another effective method of treating diabetes.

'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its relative freedom from allergenic properties. Accepted by the Council on Pharmacy and Chemistry, American Medical Association. Developed in the Wellcome Research Laboratories, Tuckahoe, New York. U.S. Patent No. 2,161,198. Available in vials of 10 cc., 80 units in 1 cc., and vials of 10 cc., 40 units in 1 cc. Literature on request. 'Wellcome' trademark registered.

'WELLCOME' Globin Insulin WITH ZINC

BURROUGHS WELLCOME & CO. (U.S.A.) INC., 9 & 11 EAST 41ST STREET, NEW YORK 17, N.Y.

Proposed Amendments to Constitution and By-Laws of Woman's Auxiliary To Be Voted on at May Meeting

AT the 1946 Annual Meeting of the Woman's Auxiliary to the Ohio State Medical Association, May 7, 8 and 9 in Columbus, suggested amendments to the Constitution and By-Laws of the Auxiliary will be presented by the Board of Directors for official action by the House of Delegates of the Auxiliary.

In compliance with the constitutional provision that suggested amendments shall be published in *The Ohio State Medical Journal* prior to the session, the proposed revisions are published herewith, with the changes or additions appearing in italics and the articles or sections appearing as they will read if the proposals are adopted:

CONSTITUTION

ARTICLE 6

OFFICERS

The officers of this Auxiliary shall be a President, a President-Elect, the Immediate Past-President, a Vice-President, a Secretary, a Treasurer, *eleven District Directors and six Directors-at-Large.* Each District Director shall supervise a district corresponding to a Councilor District of the Ohio State Medical Association. The officers as herein enumerated shall constitute the Board of Directors of this Auxiliary. All except the Immediate Past-President shall be elected by the House of Delegates.

BY-LAWS

CHAPTER 4

Sec. 4. Committees. To expedite proceedings of the House of Delegates the President, with the approval of the Board of Directors, shall appoint not less than *90 days* prior to the annual meeting *from among members of the House of Delegates* the following committees: Nominating Committee, Committee on Credentials, Committee on Resolutions, Committee on Reports, Committee on Tellers and Judges of Election; and other committees considered necessary by the President.

CHAPTER 5

Sec. 3. Terms of Officers. All officers of this Auxiliary, with the exception of the President, shall be elected at the annual meeting and shall serve for one year or until their successors are elected and qualified, *unless otherwise herein provided.*

The President shall serve for one year and shall be succeeded by the President-Elect.

The Secretary and the Treasurer shall each serve for two years, but shall be elected in alternate years.

Nothing in this chapter shall be construed as forbidding the re-election of any officer holding an office to be filled at that annual meeting *but no Director shall serve in such capacity for more than two consecutive years.*

For the purpose of making these revisions effective, be it provided that at the first election held following the adoption of these amendments, the District Directors representing the even-numbered districts shall be elected for terms of two years; the District Directors representing the odd-numbered districts for a term of one year; the Secretary for a term of two years and the Treasurer for a term of one year.

CHAPTER 6

Sec. 9. Quorum and Meetings. *Twelve* members of the Board shall constitute a quorum. Regular meetings of the Board shall be held at least three times a year, but special meetings may be called by the President. *In conjunction with its Fall meeting, the Board shall arrange for a conference of County Auxiliary Presidents and Presidents-Elect with members of the Board and committee chairmen of this Auxiliary.*

CHAPTER 7

Section 1. Appointment. The President with the approval of the Board of Directors shall appoint the following standing committees, members of which shall serve for one year or until their successors have been appointed and qualified: Finance, Organization, Program, Legislative, Annual Meeting, Public Relations, Hygeia, Publicity, Historical. The Finance Committee shall consist of three members of the Board. *The chairman of any of the above committees, except the Finance Committee, may be appointed by the President from among the Directors-at-Large.*

Urological Essay Prize

The American Urological Association offers an annual award, not to exceed $500, for an essay (or essays) on the result of some specific clinical or laboratory research in urology. Competitors are limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years. All interested should write the secretary for full particulars. The selected essay (or essays) will appear on the program of the meeting of the American Urological Association, to be held at the Netherland Plaza, Cincinnati, July 22-25, 1946. Essays must be in the hands of the secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee, on or before July 1, 1946.

More pleasure to you, Doctor!

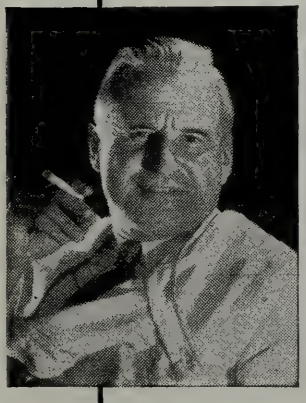
THREE nationally known research organizations recently reported the results of a nationwide survey to discover the cigarette preferences of physicians and surgeons.

Physicians all over the United States were asked the simple question: "What cigarette do you smoke, Doctor?" The question was put solely on the basis of *personal preference as a smoker.*

The thousands and thousands of answers from these physicians in every branch of medicine were checked and re-checked. The result:

> **More physicians named Camel as their favorite smoke than any other cigarette. And the margin for Camels was most convincing.**

Certainly the average physician is busier today than ever before and is deserving of every bit of relaxation he can find in his day-by-day routine . . . a cigarette now and then if he likes. And the makers of Camels are glad to know that physicians find in Camels that extra margin of smoking pleasure that has made Camels such a favorite everywhere.



According to this recent nationwide survey:

More Doctors Smoke Camels

than any other cigarette



R. J. Reynolds Tobacco Company, Winston-Salem, N. C.

In Memoriam

Rocco Marcus Antonelli, M.D., Youngstown; Electic Medical College, Cincinnati, 1919; aged 58; died Jan. 2. Dr. Antonelli practiced in Youngstown until his retirement two years ago. Surviving are two brothers, a step-brother, and three sisters.

Wylie McLean Ayres, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1900; aged 71; died Dec. 22; former member of the Ohio State Medical Association and the American Medical Association. A lifelong resident of Cincinnati, Dr. Ayres retired from practice a few years ago, and devoted his time to travel. His wife died last February. Surviving are two sisters and a brother.

Elmer E. Burns, M.D., Kirby; Columbus Medical College, Columbus, 1890; aged 81; died Jan. 7; former member of the Ohio State Medical Association and the American Medical Association. A former mayor of Kirby, Dr. Burns practiced medicine in Wyandot County for half a century.

Allen Coburn, M.D., Homer; Starling Medical College, Columbus, 1905; aged 76; died Dec. 16; former member of the Ohio State Medical Association and the American Medical Association. Dr. Coburn practiced medicine in Utica and Homer, Licking County, for a number of years until his retirement in 1944. He was a veteran of World War I and a member of the American Legion, First Methodist Church and the Masonic Order. His widow, two sons, a daughter, and one sister survive.

Harvey Elmer Corl, M.D., Middlebranch; Jefferson Medical College of Philadelphia, 1893; aged 78; died Jan. 3; former member of the Ohio State Medical Association and the American Medical Association. Dr. Corl practiced medicine in Middlebranch for more than 50 years, and was a former president of the Stark County Medical Society. He and Mrs. Corl celebrated their golden wedding anniversary in May, 1944. Dr. Corl was a member of the Masonic Lodge and the United Brethren Church. Surviving are his widow and five sisters.

Harry L. Fiscus, M.D., Reinersville; Baltimore University School of Medicine, Baltimore, Md., 1897; aged 76; died Jan. 6; member of the Ohio State Medical Association and the American Medical Association. Dr. Fiscus located in Reinersville in 1913, and for 33 years practiced medicine in Morgan, Noble, and Washington Counties. He served as county coroner from 1919 to 1929, and was re-elected in 1944. From 1915 to 1936 he was a member of the Manchester board of education, serving much of the time as its president. He was a member of the Masonic Lodge. Surviving are his widow, one daughter, three step-daughters, one brother, and a sister.

Florence S. Goodhue, M.D., Cardington; Cleveland University of Medicine and Surgery, Cleveland, 1884; aged 85; died Jan. 2. Dr. Goodhue practiced medicine in Cardington for 31 years and retired in 1923 to live in Florida until 1943, when she returned to Cardington. She was a member of the Order of Eastern Star and the Episcopal Church. Surviving are four brothers and two sisters.

Augustus Clarkson Grove, M.D., Jewett; Starling Medical College, Columbus, 1889; aged 81; died Dec. 22; former member of the Ohio State Medical Association and the American Medical Association. Dr. Grove was a former president and delegate of the Harrison County Medical Society and was active in county affairs for over half a century. He was a member of the Presbyterian Church and the Masonic Lodge. Surviving are two children, a brother, and four sisters.

James Owen Howells, M.D., Bridgeport; University of Pennsylvania School of Medicine, Philadelphia, 1894; aged 83; died Jan. 4; member of the Ohio State Medical Association; Fellow of the American Medical Association; Fellow of the American College of Surgeons. Dr. Howells was the oldest member of the Belmont County Medical Society and was president and delegate of the organization in 1942.

Thomas Welford Lear, M.D., Coshocton; Eclectic Medical College, Cincinnati, 1894; aged 74; died Dec. 17; member of the Ohio State Medical Association and the American Medical Association. Dr. Lear had practiced medicine for 51 years and was a former president of the Coshocton County Medical Society. He was a member of the Nazarene Church. Surviving are his widow; a son, Dr. Harold W. Lear, Coshocton; a daughter, one brother, and five sisters.

William Henry Phillips, M.D., Cleveland; Cleveland Medical College, Homeopathic, 1893; aged 74; died Dec. 19; member of the Ohio State Medical Association, the American Medical Association, and a Fellow of the American College of Surgeons. Dr. Phillips was a practicing ophthalmologist for 53 years, the last 15 years of which were in joint practice with his wife, Dr. Josephine Derion Phillips. Dr. Phillips studied abroad, on the continent and in England and Scotland, and later traveled in China, Africa, and in the South Pacific. He was on the staff of Huron Road and Glenville Hospitals and a member of

FIFTH IN A SERIES OF CHALLENGES TO MEDICINE'S

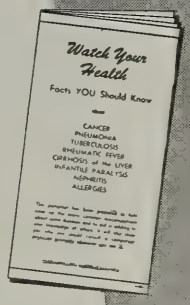
Achievements For Tomorrow

● NEPHRITIS stood fourth in causes of death in 1942*.

This is one disease from which thousands could be saved if people were educated to visit their physicians for periodic checkups, because nephritis gives no warning symptoms in its early stages. A physician's thorough examination and tests would disclose the otherwise unsuspected nephritic condition.

To help in educating the laity in the importance of regular examinations, we have prepared a pamphlet — "Watch Your Health". Nephritis is one of the seven serious diseases explained in simple terms. Copies are available to physicians on request.

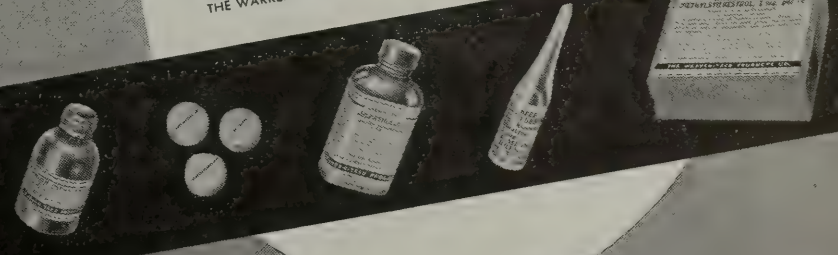
* U. S. Summary of Vital Statistics, 1942.



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the Cleveland Medical Library Association. His widow survives.

Irwin William Sherwood, M.D., Columbus; Starling Medical College, Columbus, 1901; aged 76; died Dec. 31; member of the Ohio State Medical Association and the American Medical Association. Having practiced medicine in Columbus for 45 years, Dr. Sherwood had recently retired from active practice. Surviving are his widow, two daughters, a brother, and a sister.

Lawrence Shields, M.D., Xenia; Medical College of Ohio, Cincinnati, 1895; aged 74; died Jan. 9; member of the Ohio State Medical Association, and a Fellow of the American Medical Association. Dr. Shields served his internship at the old General Hospital, Cincinnati, and became its first resident surgeon in 1896. He later served for several years as director of the American Hospital in Mexico City, after which he studied in Vienna, Austria. Upon his return to the United States he established practice in Xenia. He is survived by his widow and a brother.

Thomas Milton Stewart, M.D., Cincinnati; Pulte Medical College, Cincinnati, 1887; aged 79; died Dec. 10; member of the Ohio State Medical Association; Fellow of the American Medical Association; Fellow of the American College of Surgeons; life Fellow of the Academy of Ophthalmology and Oto-Laryngology. Dr. Stewart studied abroad and in 1890 returned to Cincinnati to begin his career of more than 50 years. He was well known as an author and lecturer; was a member of the Masonic Lodge and of the Authors' Lodge and Quatour Coronati Lodge of London, England. Surviving him are his widow and a sister.

Harry Hill Van Kirk, M.D., Delaware; Starling Medical College, Columbus, 1898; aged 73; died Jan. 3; Fellow of the American Medical Association. Dr. Van Kirk entered the Army in 1900, and retired from active service in 1932 as a lieutenant colonel. He served as assistant professor of military science and tactics in the Ohio State University medical R. O. T. C. unit from 1928 to 1932, and previously served in a similar capacity at Western Reserve University School of Medicine. He is survived by his widow, a son, and a daughter.

Robert Andrew Warren, M.D., Cleveland; Western Reserve University School of Medicine, 1914; aged 61; died Dec. 25; member of the Ohio State Medical Association and a Fellow of the American Medical Association. A native of Steubenville, Dr. Warren had practiced medicine in Cleveland for 30 years. He was active in the Masonic Order, affiliated with Phi Rho Sigma fraternity; the Christian Church, and the Kiwanis Club. Surviving are his widow, two daughters, a sister and two brothers, one of them being Dr. A. W. Warren of Canton.

Buckeye News Notes

Akron—Dr. J. T. Villani has been named superintendent of Edwin Shaw Sanatorium, succeeding the late Dr. Clarence L. Hyde.

Ashland—Dr. L. G. Sheets is the new president of the city board of health, of which Dr. G. D. Fridline also is a member.

Cincinnati—The Nutrition Council of the Cincinnati Public Health Federation recently sponsored a "Better Breakfast" week.

Columbus—Dr. I. B. Harris, professor of clinical surgery, Ohio State University College of Medicine, has retired from the faculty and been named emeritus professor. He will continue in private practice.

Dayton—Recently returned from military service, Dr. Richard Hochwalt was guest speaker at a meeting of the Southwestern District, Ohio Chapter, American Physiotherapy Association.

Ironton—An addition to General Hospital as a memorial to veterans of World War II was proposed by Dr. Ralph Massie at a meeting of the Rotary Club.

Kent—Dr. A. O. DeWeese has been named president of the Kiwanis Club.

Kinsman—Dr. Robert L. Thomas is the new health commissioner of Trumbull County.

Mansfield—Dr. Charles L. Shafer, back in private practice after three and one-half years in the Army Medical Corps, spoke on "Hospitals at the Front", at a meeting of the Kiwanis Club.

Marengo—Dr. F. E. Thompson, who retired a few years ago from the active practice of medicine, has been presented with the 50-year Masonic Jewel, in honor of his 50 years of membership in the order.

Massillon—New officers of the City Hospital staff are: Dr. R. W. Croyle, president; Dr. C. D. Rian, vice-president; Dr. R. H. Weinrich, secretary-treasurer.

Medina—The following officers of Community Hospital Staff have been reelected: Dr. R. L. Mansell, Medina, president; Dr. F. C. Reutter, Valley City, vice-president, and Dr. R. F. Fasoli, Brunswick, secretary-treasurer.

Middletown—Dr. J. A. Carter is the new city health commissioner.

Salem—Staff officers of City Hospital are: Dr. L. F. Derfus, chief; Dr. F. R. Crowgey, vice-president, and Dr. L. C. Ziegler, secretary.

Stryker—Dr. Charles G. Goll has been appointed health commissioner of Williams County.

Youngstown—Dr. H. E. McClenahan is the new president of the Kiwanis Club.

Washington C. H.—Four trustees have been named by Governor Frank J. Lausche, to direct the construction of the Fayette County Memorial Hospital, for which the voters of that county approved a bond issue of $360,000 last Fall.

The Preference is Overwhelming

A comprehensive report published in *Human Fertility*[1] shows an overwhelming preference by experienced clinicians for the "Diaphragm and Jelly" method of conception control.

The report covering 36,955 new cases shows that the diaphragm and jelly method was prescribed for 34,314, or 93%.

On the evidence supplied by competent clinicians we continue to suggest that for the optimum in protection the physician should prescribe the combined use of a vaginal diaphragm and spermatocidal jelly.

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1. Human Fertility, 10:25, March, 1945.



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Activities of County Societies

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

ADAMS

Officers of the Adams County Medical Society for 1946 are: Dr. Robert B. Ellison, Peebles, pres.; Dr. Robert L. Lawwill, Seaman, pres.-elect; Dr. Hazel L. Sproull, West Union, secy.-treas.; Dr. S. J. Ellison, West Union, delegate.

BUTLER

Dr. Nicholas J. Giannestras, Cincinnati, spoke on "Ankle Injuries", at a meeting of the Butler County Medical Society, Nov. 29, at Middletown Hospital.—News clipping.

CLINTON

At the January meeting of the Clinton County Medical Society, Dr. J. G. Anderson, Lynchburg, spoke on his experience and medical service in World War II.—R. W. DeCrow, M. D., secretary.

HAMILTON

Dr. Bruce K. Wiseman, Columbus, professor of medicine, Ohio State University College of Medicine, discussed the subject, "Hypersplenism in the Blood Dyscrasias", at the January 8 meeting of the Academy of Medicine of Cincinnati.—Bulletin.

On January 22, Dr. H. Houston Merritt, professor of clinical neurology, Columbia University College of Physicians and Surgeons, New York, addressed the Academy on the subject, "The Treatment of Epilepsy".

HIGHLAND

The following Hillsboro physicians are officers of the Highland County Medical Society for 1946: Dr. J. C. Larkin, pres.; Dr. J. D. McBride, vice-pres.; Dr. W. B. Roads, secy. Dr. Martin Byers, Greenfield, was selected as chairman of the legislative committee.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

CHAMPAIGN

Elected as officers of the Champaign County Medical Society for 1946 were the following Urbana physicians: Dr. V. G. Wolfe, pres.; Dr. V. R. Frederick, pres.-elect; Dr. I. Miller, secy.-treas.; Dr. D. C. Houser, delegate; Dr Mark Houston and Dr. E. R. Earle, alternates.

DARKE

The Darke County Medical Society heard a discussion of the Rh Blood Factor by Dr. J. R. Alley, Greenville, at the dinner meeting of the organization on January 15. Dr. Alley has had considerable Army experience in this field.—W. D. Bishop, M. D., secretary.

MIAMI

Dr. C. C. Burton, chief of the surgical service of the Dayton Veterans' Hospital, presented a paper on "Hernioplasty" before the January 4 meeting of the Miami County Medical Society held at the Memorial Hospital in Piqua. Dr. Burton, formerly a lieutenant colonel in the Army Medical Corps, illustrated his talk with lantern slides and sound movies.—Bulletin.

SHELBY

The 1946 officers of the Shelby County Medical Society have been elected as follows: Dr. E. P. Sparks, Sidney, pres.; Dr. J. W. Tirey, Anna, pres-elect; Dr. R. L. Wiessinger, Sidney, secy.-treas.; Dr. H. C. Clayton, Sidney, delegate, and Dr. C. B. Conover, Sidney, alternate.

Third District

(COUNCILOR: GUY E. NOBLE, M.D., ST. MARYS)

ALLEN

The following Lima physicians are officers of the Academy of Medicine of Lima and Allen County for 1946: Dr. C. L. Steere, pres.; Dr. H. C. Weisenbarger, pres.-elect; Dr. H. H. Brueckner, secy.; Dr. M. A. Mulvania, treas.; Dr. J. R. Johnson, delegate; Dr. Burt Hibbard, alternate.

AUGLAIZE

Officers of the Auglaize County Medical Society for 1946 are: Dr. T. H. Will, Minster, pres.; Dr. Alfred W. Veit, Wapakoneta, vice-pres. and secy.-treas.; Dr. R. C. Hunter, Wapakoneta, delegate; Dr. E. Y. Kuffner, St. Marys, alternate.

HARDIN

Hardin County Medical Society officers for 1946 are: Dr. J. A. Mooney, Kenton, pres.; Dr. C. L. Johnson, Kenton, pres.-elect; Dr. R. H. Zeis, Kenton, secy.-treas.; Dr. H. A. Kerns, Kenton, delegate; Dr. F. M. Elliott, Ada, alternate.

LOGAN

Dr. O. P. Allen, Akron, addressed the Logan County Medical Society meeting of January 4 on the subject, "Diabetes". At the same meeting Dr. Charles L. Barrett presented a case report of considerable interest.—F. W. Kaylor, M. D., secretary.

Members of the society held a dinner session at the Hotel Logan, Bellefontaine, Dec. 7, in honor of Dr. Carrie A. Richeson, now in her 52nd year of active practice. Dr. Richeson was presented with a chair and a bouquet of roses. Dr. J. P. Harbert spoke on behalf of the society



For the symptomatic relief of sinusitis...

"The benzedrine inhaler is an excellent vasoconstrictor and unless overindulged in, it may be used conveniently for long periods without deleterious results." Moore, J. H.: A Resume of Conservative Sinus Management, Southern Med. J. 34: 848-854.

The vasoconstrictive vapor of Benzedrine Inhaler, N.N.R., diffuses evenly throughout the upper respiratory tract, opening sinal ostia and ducts which are frequently inaccessible to liquid vasoconstrictors. The sinuses drain. Headache, pressure pain, "stuffiness" and other unpleasant sinusitis symptoms are relieved. Each Benzedrine Inhaler is packed with racemic amphetamine, S.K.F., 200 mg.; menthol, 10 mg.; and aromatics. Smith, Kline & French Laboratories, Phila., Pa.



Benzedrine Inhaler

...a better means of nasal medication

in appreciation of Dr. Richeson's long years of service to the community.—News clipping.

MARION

At a combined business and program meeting of the Marion Academy of Medicine, January 8, a technicolor motion picture "Communicable Diseases", arranged for by Dr. R. T. Gray, was presented by Dr. W. A. Pennington.—News clipping.

SENECA

The following Tiffin physicians are officers of the Seneca County Medical Society for 1946: Dr. William R. Funderburg, pres.; Dr. John A. Gosling, pres.-elect; Dr. A. W. Harrold, secy.-treas.; Dr. R. F. Machamer, delegate; Dr. Paul J. Leahy, alternate,

VAN WERT

The Van Wert County Medical Society has selected the following Van Wert physicians as officers for 1946: Dr. O. J. Fatum, pres. and delegate; Dr. Wayne C. Smith, pres.-elect; Dr. H. D. Underwood, secy. and alternate.

Fourth District

(COUNCILOR: A. A. BRINDLEY, M.D., TOLEDO)

DEFIANCE

Members of the Defiance County Medical Society have elected the following officers for 1946: Dr. D. J. Slosser, Defiance, pres. and delegate; Dr. J. S. Hull, Hicksville, vice-pres.; Dr. E. P. Mitchell, Defiance, secy.-treas.; Dr. Paul B. Newcomb, Defiance, alternate.

FULTON

The following officers have been elected by the Fulton County Medical Society for 1946: Dr. A. M. Wilkins, Delta, pres. and alternate; Dr. L. C. Cosgrove, Jr., Swanton, pres.-elect; Dr. L. C. Cosgrove, Sr., Swanton, secy.-treas. and delegate.

HENRY

The following physicians are the 1946 officers of the Henry County Medical Society: Dr. R. L. Gilson, Napoleon, pres.; Dr. H. J. Wenzinger, Holgate, vice-pres.; Dr. J. R. Bolles, Napoleon, secy.-treas., chmn. of legislative committee and delegate; Dr. Thomas Quinn and Dr. T. P. Delventhal, Napoleon, alternates.

LUCAS

At the 44th Annual Meeting of the Academy of Medicine of Toledo and Lucas County, held January 4, the following officers, all from Toledo, were chosen for 1946: Dr. E. C. Mohr, pres.; Dr. M. W. Diethelm, pres.-elect; Dr. R. J. Borer, secy.; Dr. John L. Stifel, trustee; Dr. E. A. Ockuly, councilman. C. Ollin Ball, Ph. D., Owens Illinois Glass Company, speaker of the evening, discussed the subject, "Observations in Europe".

Jan. 11—Section of Pathology, Experimental Medicine and Bacteriology. "Chemical Changes in the Nose in Relation to Some Diseases of the Nasal Passages", Albert Dietz, Ph. D., Toledo Hospital Institute of Medical Research. "Intraocular Pressure. An Experimental Evaluation", Dr. Ernest Schmerl, Toledo Hospital Institute of Medical Research.

Jan. 18—Medical Section. "Observations on the Use of Thiouracial in Thyrotoxicosis", Dr. William S. Reveno, assistant professor of clinical medicine, Wayne University College of Medicine, and consultant of medicine, Detroit Receiving Hospital, Highland Park General Hospital, Detroit.

Jan. 25—Surgical Section. "The Study of Human Fertility and Sterility", Dr. J. L. Reycraft, Western Reserve University.—Bulletin.

PUTNAM

Officers of the Putnam County Medical Society for 1946 are: Dr. Carl H. Zinsmeister, Ottawa, pres.; Dr. Milo B. Rice, Pandora, vice-pres.; Dr. A. H. Nihizer, Vaughnsville, secy.-treas.; Dr. H. N. Trumbull, Columbus Grove, delegate; Dr. H. A. Neiswander, Pandora, alternate.

Honoring Dr. Charles J. Ray, Gilboa, who is completing 50 years in the practice of medicine, members of the Putnam County Medical Society and their wives had a dinner meeting Nov. 13, at Columbus Grove. Dr. M. B. Rice, Pandora, was the principal speaker.—News clipping.

WILLIAMS

Members of the Williams County Medical Society have elected the following officers for 1946: Dr. D. D. Odell, Bryan, pres.; Dr. T. L. Taylor, Montpelier, vice-pres.; Dr. P. G. Meckstroth, Bryan, secy.-treas.; Dr. H. W. Wertz, Montpelier, delegate

WOOD

The following Bowling Green physicians have been elected as officers of the Wood County Medical Society: Dr. Frank V. Boyle, pres.; Dr. R. N. Whitehead, pres.-elect; Dr. E. H. Mercer, Sr., secy.-treas.

Fifth District

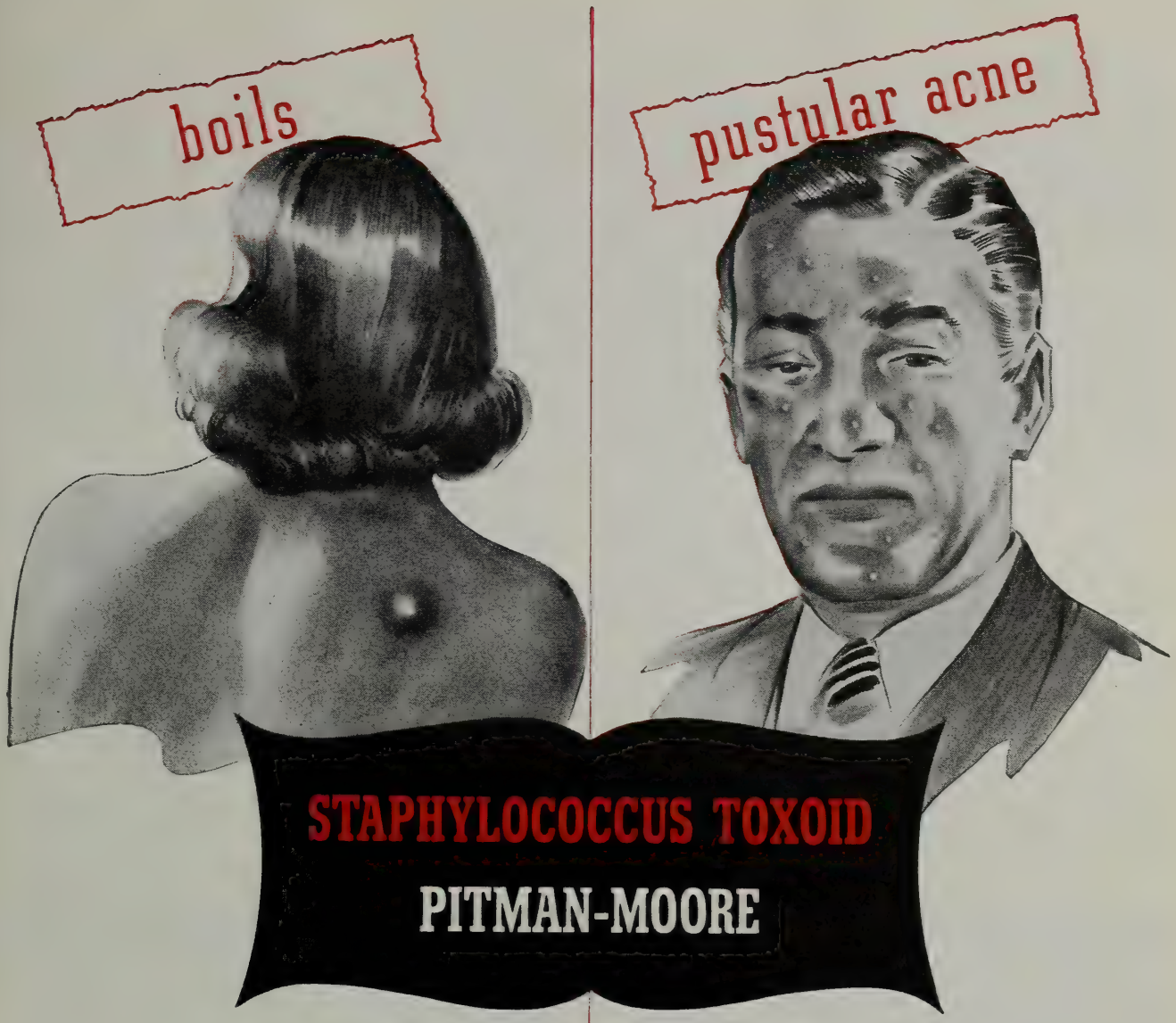
(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

CUYAHOGA

The following Cleveland physicians are officers of the Academy of Medicine of Cleveland for 1946: Dr. F. T. Gallagher, pres.; Dr. R. B. Crawford, vice-pres.; Dr. R. F. Parker, secy.-treas.

At the regular meeting of the academy on January 11, Dr. W. D. Stroud, professor of cardiology, University of Pennsylvania Graduate School of Medicine, discussed "Cardiovascular Diseases".

Speaker at the annual meeting of the Cleveland Medical Library Association, January 18, was Dr. Herbert B. Wright of that city. A colonel in the Army Medical Corps, World War II,



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A growing literature reports the value of Staphylococcus Toxoid in the prophylaxis and therapy of various staphylococcic pyodermas and localized pyogenic processes due to *S. aureus* and *albus*. The toxoid induces the production of staphylococcus antitoxin in immunized persons, and there is accumulating evidence of its value in producing active immunity to the dermonecrotic and hemolytic elements of the toxins of *S. aureus* and *albus*, irrespective of the strain of the infecting organism.

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- Recurrent migratory staphylococcus abscesses of soft tissues and bone
- Staphylococcal infection of accessory nasal sinuses
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Dr. Wright spoke on "Medical Reminiscences of the European War".—Bulletin.

GEAUGA

Officers of the Geauga County Medical Society for 1946 are: Dr. W. A. Reed, Burton, pres.; Dr. H. E. Shafer, Middlefield, vice-pres.; Dr. Isa Teed Cramton, Burton, secy.-treas.

LAKE

Dr. Robert M. Hosler, Cleveland, recently spoke to the Lake County Medical Society members and families on the subject, "Present Trends in Medical Legislation".

Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

MAHONING

Major Fred S. Coombs, Youngstown, discussed "Therapeutic and Toxic Effects of Salicylates" before the January 15 meeting of the Mahoning County Medical Society. Officers of the society for 1946 are: Dr. Edward J. Reilly, Campbell, pres.; Dr. G. M. McKelvey, Youngstown, pres.-elect; Dr. V. L. Goodwin, Youngstown, secy.; Dr. P. J. McOwen, Youngstown, treas.; Drs. E. J. Wenaas, Youngstown, John N. McCann, Youngstown, and Wm. M. Skipp, Canfield, delegates; Drs. E. C. Baker, J. J. McDonough, and W. J. Tims, all of Youngstown, alternates.—Bulletin.

STARK

Officers of the Stark County Medical Society for 1946 are: Dr. L. E. Leavenworth, Canton, pres.; Dr. J. H. Bahrenburg, Canton, pres.-elect; Dr. L. E. Anderson, Greentown, secy.-treas.; Dr. A. R. Basinger, North Canton, delegate; Dr. Graydon Underwood, Navarre, alternate.

SUMMIT

"American Principles" was the subject of Judge Walter B. Wanamaker's address to the Summit County Medical Society on January 8. Drs. F. T. Moore, F. A. Smith, and A. M. Weil talked briefly on "War Experiences", and new officers of the soceity were installed.—Bulletin.

TRUMBULL

The following are officers of the Trumbull County Medical Society for 1946: Dr. E. L. MacDougal, Warren, pres.; Dr. Harry Smith, Bristolville, vice-pres.; Dr. E. G. Caskey, Mineral Ridge, secy.-treas.; Dr. R. D. Herlinger, Warren, delegate; Dr. D. L. Beers, Warren, alternate.

Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

JEFFERSON

The following Steubenville physicians are the officers of the Jefferson County Medical Society for 1946: Dr. Howard W. Brettell, pres.; Dr. D.



R. Cahill, pres.-elect; Dr. Walter A. Cunningham, secy.-treas.; Dr. Earl Rosenblum, delegate; Dr. John F. Gallagher, alternate; Dr. E. J. C. Sander, legislative committeeman.

TUSCARAWAS

Dr. R. S. Rosedale, Canton, showed a color movie on plastic surgery at the January 10 meeting of the Tuscarawas County Medical Society. New officers of the society include: Dr. Max Shaweker, Dover, pres.; Dr. Daniel Hostetler, Sugarcreek, vice-pres.; Dr. C. J. Miller, New Philadelphia, secy.-treas.; Dr. Jay W. Calhoon, Uhrichsville, delegate; Dr. B. O. Burkey, Baltic, alternate.—Bulletin.

Eighth District

(COUNCILOR: GEORGE F. SWAN, M.D., CAMBRIDGE)

LICKING

The following Newark physicians have been named as the officers of the Licking County Medical Society for 1946: Dr. Paul C. Grove, pres.; Dr. J. Fleek Miller, pres.-elect and alternate; Dr. R. G. Plummer, secy.-treas.; Dr. Arthur J. Tronstein, delegate.

WASHINGTON

Officers of the Washington County Medical Society for 1946 are: Dr. T. R. Mattocks, Marietta, pres.; Dr. F. E. Eddy, Marietta, vice-pres.; Dr. R. H. Sloan, Marietta, secy.-treas; Dr. W. E. Radcliffe, Caldwell, delegate; Dr. J. A. McCowan, Marietta, alternate

Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

GALLIA

Gallia County Medical Society officers for 1946 are: Dr. N. Howard Foster, Gallipolis, pres.; Dr. Paul C. Foster, Gallipolis, secy.-treas.; Dr. Francis W. Shane, Gallipolis, delegate.

MEIGS

The following physicians have been elected as officers of the Meigs County Medical Society for 1946: Dr. F. M. Cluff, Middleport, pres.; Dr. Roger P. Daniels, Pomeroy, pres.-elect; Dr. Robert R. Boice, Pomeroy, secy.-treas.; Dr. R. E. Boice, Middleport, delegate; Dr. W. S. Ellis, Pomeroy, alternate.

Tenth District

(COUNCILOR: GEORGE T. HARDING, M.D., COLUMBUS)

DELAWARE

The Delaware County Medical Society has elected the following officers for 1946: Dr. A. R. Callander, Delaware, pres.; Dr. D. S. James, Delaware, vice-pres.; Dr. F. M. Stratton, Delaware, secy.-treas.; Dr. M. W. Livingston, Sun-



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bury, delegate; Dr. F. V. Miller, Delaware, alternate.

FRANKLIN

At a meeting held January 7 in the Columbus Art Gallery, Dr. Marion A. Blankenhorn, professor of medicine, University of Cincinnati College of Medicine, spoke before the Columbus Academy of Medicine on the significant advances in medicine during 1945. At the January 21 meeting of the Academy the following Columbus doctors discussed "Malaria": Dr. Edward G. Klopfer, recently returned from the South Pacific Theater; Dr. Willis B. Merrill, CBI Theater; Dr. Hall S. Wiedemer, Mediterranean Theater.

The 1946 officers of the Academy are: Dr. Horace B. Davidson, pres.; Dr. Charles W. Pavey, pres.-elect; Dr. John E. Martin, secy.-treas.; Dr. J. Mitchell Dunn, trustee; Drs. Drew L. Davies and George J. Heer, delegates; Drs. John J. Gallen, Columbus, and William L. Pritchard, Hilliards, alternate.

KNOX

Officers of the Knox County Medical Society for 1946 are: Dr. Charles Baldwin, Centerburg, pres.; Dr. Raymond Lord, Fredericktown, pres.-elect; Dr. John Baube, Mt. Vernon, secy.-treas.

MADISON

New Madison County Medical Society officers are Dr. H. E. Karrer, Plain City, pres., and Dr. G. C. Scheetz, West Jefferson, secy.-treas.

MORROW

Morrow County Medical Society members have chosen the following officers for 1946: Dr. Frank H. Sweeney, Mt. Gilead, pres.; Dr. W. E. DeVol, Marengo, vice-pres.; Dr. F. M. Hartsook, Cardington, secy. and alternate; Dr. J. P. Ingmire, Mt. Gilead, delegate.

PICKAWAY

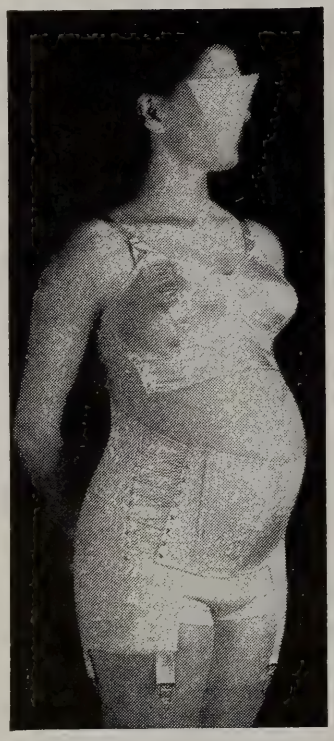
The following Circleville physicians are officers of the Pickaway County Medical Society for 1946: Dr. D. V. Courtright, pres.; Dr. H. D. Jackson, pres.-elect; Dr. W. F. Heine, secy.-treas.; Dr. E. S. Shane, delegate; Dr. A. D. Blackburn, alternate

ROSS

Dr. Harry Sage, Columbus, spoke on the subject, "My Experiences in Four Years at Sea" at the December 6 meeting of the Ross County Academy of Medicine. At the January 3 meeting of the organization, Dr. L. H. Schriver, Cincinnati, President of the Ohio Medical Association, decried the tendency toward regimentation and recommended that doctors in their various communities take a more active part in public health and civic matters. He also discussed activities of the State Association.

New Ross County officers are the following Chillicothe physicians: Dr. M. D. Scholl, pres.; Dr. Walter E. Kramer, pres.-elect; Dr. Ralph W.

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UNION

Union County Medical Society officers for 1946 are: Dr. B. E. Ingmire, Plain City, pres.; Dr. J. M. Snider, Marysville, secy.-treas.; Dr. Evert J. Marsh, Broadway, delegate; Dr. Herman C. Duke, Richwood, alternate.

Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

ERIE

The following Sandusky physicians have been elected officers of the Erie County Medical Society for 1946: Dr. W. F. Burger, pres.; Dr. W. T. Fenker, vice-pres.; Dr. E. J. Meckstroth, secy.-treas. and alternate; Dr. V. A. Killoran, delegate.

HOLMES

The following Millersburg physicians have been named as officers of the Holmes County Medical Society for 1946: Dr. N. P. Stauffer, pres.; Dr. A. J. Earney, secy.-treas.; Dr. A. T. Cole, delegate; Dr. J. C. Elder, alternate.

HURON

Huron County Medical Society officers for 1946 are: Dr. H. C. Sparks, Monroeville, pres. and delegate, Dr. Charles H. Edel, Norwalk, pres.-elect; Dr. George F. Linn, Norwalk, secy.-treas. and alternate.

LORAIN

The January 8 meeting of the Lorain County Medical Society was devoted to a discussion of the hospital needs of the county. Mr. Guy Clarke, Cleveland, secretary of the Cleveland Hospital Association, spoke at the session.—L. H. Trufant, M. D., secretary.

MEDINA

Officers of the Medina County Medical Society for 1946 are: Dr. H. T. Pease, Wadsworth, pres.; Dr. R. L. Mansell, Medina, pres.-elect; Dr. E. C. Bell, Lodi, secy.-treas.; Dr. N. J. M. Klotz, Wadsworth, delegate; Dr. R. F. Fasoli, Brunswick, alternate.

RICHLAND

Richland County Medical Society officers for 1946 are: Dr. Ralph E. Wharton, Mansfield, pres.; Dr. L. B. McCullough, Mansfield, pres.-elect; Dr. George L. Evans, Mansfield, secy.-treas.; Dr. John S. Hattery, Mansfield, delegate; Dr. J. F. McHugh, Shelby, alternate.

WAYNE

The following Wooster physicians are officers of the Wayne County Medical Society for 1946: Dr. R. N. Wright, pres.; Dr. H. G. Beeson, pres.-elect; Dr. R. C. Paul, secy.-treas. and alternate; Dr. F. C. Gaynard, delegate.

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WOMAN'S AUXILIARY NEWS

(BY MRS. FRED W. BROSIUS, MIDDLETOWN)
Chairman, Publicity Committee

BUTLER

The members of the Woman's Auxiliary to the Butler County Medical Society met for luncheon at the YWCA, Hamilton, on November 26. Thirty-five members and guests were present. Mrs. Fred Brosius, president, presided at the business meeting. A report of the state conference was given by the president, with emphasis on the Wagner-Murray-Dingell Bill and the drive for medical samples for European war relief. Mrs. David Gerber and Mrs. H. J. Baker reported that *Hygeia* and bulletin subscriptions have exceeded all previous years. Mrs. Charles T. Atkinson, public relations chairman, revealed that over 800 pounds of drugs had been shipped to Akron for War Relief. The Ways and Means Committee, with Mrs. Walter Roehll as chairman, reported a profit of $112.00 from the benefit dinner and bingo party given by the auxiliary members and their husbands. The proceeds will be used for awards to two senior student nurses excelling in special nursing arts. Mrs. Ross Hill and Mrs. C. J. Chamberlin were elected Delegate and Alternate to the State Convention in May.

"Musical Heritage" was the interesting subject of Mrs. C. H. Williams' program. Mrs. Williams delighted her audience by tracing the history of American music from the time of the earliest Indian calls to the present day "blues". Excerpts of the various compositions were played on the piano by the speaker.

Mrs. Melvin Fishman, publicity chairman for the auxiliary, has the unique distinction of being society editor for the *Middletown Journal*. Recently Mrs. Fishman received state recognition as one of the top-notch writers in the newspaper field. New members welcomed were Mrs. L. H. Skimming, Mrs. Corliss Keller, Mrs. John Borelli, Mrs. John Carter, Mrs. Mark Millikin, Mrs. Lee Brown, Mrs. Jack Harris, Mrs. Malcolm Cook, Mrs. C. E. Bolinger, Mrs. W. A. Davin, and Mrs. William Vinnedge.

CUYAHOGA

A luncheon meeting was enjoyed by the Woman's Auxiliary to the Cleveland Academy of Medicine, December 6, at the Cleveland Hotel. Being the annual meeting, new officers and directors were elected for the year 1946. Out-going officers are: Mrs. I. F. Weidlein, president Mrs. Farrell T. Gallagher, vice-president Mrs. C. A. Black, secretary-treasurer. Mrs. C. A. Swan, chairman of Red Cross knitting, reported 1,147 articles made by the Auxiliary during the war period, including 97 afghans for which wool was donated by the members. Mrs. R. A. Scherz heads a committee providing guides and hostesses for the Cleveland Museum. Mrs. W. F. Creadon,

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OBSTETRICS — Two Weeks Intensive Course starting March 11.

PEDIATRICS — Four Weeks Intensive Course starting March 4.

MEDICINE—Two Weeks Intensive Course starting February 18 and April 8.

DERMATOLOGY & SYPHILOLOGY—Two Weeks Course starting April 8.

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legislative chairman, keeps members informed on all current medical legislation. Mrs. D. M. Keating, press and publicity chairman, is taking an active part in auxiliary news. Guest speaker was Mrs. Henry Eduard Rombouts, wife of a Dutch physician and active in American Relief for the Netherlands. Mrs. Rombouts gave a detailed account of her life in Holland and her later experience being exacuated from Borneo and Java.

FRANKLIN

The Woman's Auxiliary to the Columbus Academy of Medicine has inaugurated a unique and interesting plan to provide funds for a philanthropic project sponsored by the auxiliary members. Mrs. George W. Cooperrider president, and members of the organization enthusiastically carried out plans for a large number of bridge parties and book reviews for non-bridge players, on November 19. Proceeds from the benefit parties will be used to furnish occupational equipment for local institutions. Mrs. Phillip Knies, Columbia Ave., entertained one group to hear Mrs. Depew Head review "All Our Lives". Mrs. A. Ahn and Mrs. M. Davies assisted. Mrs. Earl Baxter was hostess to another group, assisted by Mrs. Stuart Cromer and Mrs. William Hutchinson. "The Peacock Sheds His Tail" was reviewed by Mrs. George I. Nelson.

MAHONING

Mrs. L. George Coe is the new president of the Woman's Auxiliary to the Mahoning County Medical Society, having been elected during a business meeting at a Christmas party for members, December 17. Officers are: Mrs. W. K. Allsop, president-elect; Mrs. C. A. Gustafson, vice-president; Mrs. John Rogers, secretary; and Mrs. M. M. Kendall, treasurer. Mrs. A. E. Brant, retiring president, was presented with a corsage of roses by the retiring vice-president, Mrs. D. M. Rothrock.

The Christmas party was held at the Youngstown Club, where 50 members enjoyed a dinner-bridge. In charge of the festivity were the program and social committees, Mrs. George McKelvey and Mrs. A. J. Brandt, chairman and co-chairman of the program committee, and Mrs. D. A. Gross and Mrs. W. Z. Baker, chairman and co-chairman of the social committee.

MARION

Miss Garnet Thomasson, Red Cross club worker, was guest speaker at the December meeting of the Woman's Auxiliary to the Marion County Academy of Medicine, held at the home of Mrs. Fillmore Young. Mrs. J. A. Dodd presided at a business meeting, appointing a nominating committee composed of Mrs. B. H. Taylor, Mrs. H. K. Mouser, and Mrs. H. J. Merchant. A contribution was made to the War Chest by the

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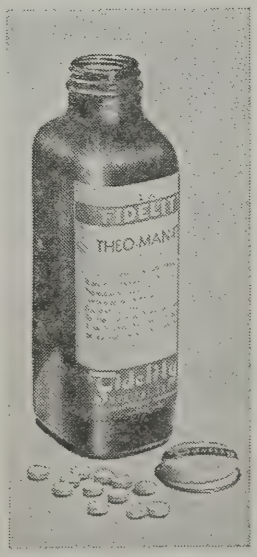
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auxiliary. A Christmas exchange was enjoyed, followed by a tea. Mrs. Dodd and Mrs. Sawyer presided at the urns.

At the January 19 meeting in the Hotel Harding, Dr. Frederick Merchant was guest speaker.

ROSS

A Christmas meeting was enjoyed by the members of the Ross County Academy Woman's Auxiliary when they had dinner at Allyn's, Chillicothe, then adjourned to the home of Mrs. R. C. Bane where supplies were made for the hospital. Later bridge was an enjoyable feature of the evening.

On January 3, the auxilary had as guests Mrs. Roswell S. Fidler, Columbus, President of the Woman's Auxiliary to the Ohio State Medical Association, and Mrs. Ross Snyder, Ross County Health Nurse. Following dinner at Allyn's the members adjourned to the home of Mrs. O. L. Iden. Mrs. L. E. Hoyt, president, introduced Mrs. Fidler, who reviewed projects of state auxiliary units and discussed future programs. Mrs. Snyder compared work done in Ross County to that described in an article, "Health at the Crossroads", published in *Hygeia*. Mrs. H. R. Brown gave a report on medical legislation.

SCIOTO

Mrs. Clyde Fitch entertained the Woman's Auxiliary to the Hempstead Academy of Medicine at Portsmouth, December 12. After a brief business session, a Christmas exchange, contests, and tea were enjoyed by the members.

The January meeting of the Woman's Auxiliary to the Hempstead Academy of Medicine was held at the home of Mrs. Harry Schirrman. Mrs. George Obrist gave an interesting book review, "The Peacock Sheds His Tail" by Alice Tisdale Hobart. The members voted to give five dollars to the Grant School to purchase vegetables for the children. Each member brought a box of raisins to the meeting, also for the above project. Refreshments and a social hour concluded the meeting.

SUMMIT

Members of the Woman's Auxiliary to the Summit County Medical Society have collected about 10,000 pounds of medical and food preparation samples to be used for relief purposes in European countries. Mrs. J. M. Ulrich was chairman of the drive.

Mrs. C. F. Wharton, president of the auxiliary, presided at the organization's Christmas party, held Dec. 5 at the Woman's City Club, Akron. Decorations were provided by Mrs. R. L. Ross of Tallmadge, and among those seated at the speaker's table were Mrs. Paul Davis, President-

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Elect of the Woman's Auxiliary to the Ohio State Medical Association, and Mrs. D. M. McDonald of the local hospitality committee. Mrs. Arnold V. Gold acting as Santa Claus, distributed gifts with the assistance of Mrs. Ralph Sommerfield, chairman of the party.

A rummage sale was held January 11 and 12 to raise funds for future projects of the auxiliary.

Red Cross Donates Blood Plasma For Distribution in Ohio

Ohio will receive 15,057 units of blood plasma as its share of a 1,250,000 package war surplus, according to word received from the American Red Cross by Dr. Roger Heering, State Health Director.

It is presumed that the plasma will be in its dried state, and packaged in 300 and 500 cubic centimeter units. The 15,057 units were set aside for Ohio, based on tentative needs for six months. Apparently more will be available after that period.

The plasma will be received and distributed by the State Department of Health under authority granted in legislation to set up a state blood bank, passed by the Ohio General Assembly in 1945.

The hospitals will be used as depots for receiving and storing the blood, which will be available to physicians upon request.

Since it is the result of donations from the public, the plasma will be free to the recipient, but physicians may charge for the administration.

College of Surgeons' Meetings

The American College of Surgeons announces the resumption in 1946 of its sectional meetings, which during the war were replaced by one-day war sessions. Scheduled meetings are as follows: Tutwiler Hotel, Birmingham, February 8 and 9; William Penn Hotel, Pittsburgh, March 11 and 12; Statler Hotel, Boston, March 18 and 19; Mt. Royal Hotel, Montreal, March 22 and 23; Statler Hotel, Detroit, March 26 and 27; Utah Hotel, Salt Lake City, April 8 and 9; Multnomah Hotel, Portland, Oregon, April 12 and 13, and the Biltmore Hotel, Los Angeles, April 17 and 18.

Chicago Clinical Conference

The Chicago Medical Society's Annual Clinical Conference is scheduled for March 5, 6, 7, and 8 at the Palmer House, Chicago. The scientific program will feature half-hour lectures beginning at 8:30 A.M. and continuing until 5 P.M. each day, with intermissions for viewing scientific and technical exhibits. A banquet is planned for Thursday evening, March 7. Reservations for rooms may be made through the Chicago Convention Bureau, 33 North LaSalle Street, Chicago.

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DEFIANCE, OHIO

New Form Gives Parents Chance To Check Birth Registration Data

The Vital Statistics Division of the State Department of Health has long been concerned about the incompleteness and incorrectness of birth certificates.

For this reason the division adopted on January 1, 1946, a special form to be known as a "universal notification birth query", which was recommended by the Vital Records Commission and adopted by a number of states. The form, to which a photostatic copy of the birth certificate is attached, is being mailed by the Division of Vital Statistics to the parents.

This form will advise the parents that the birth of their child has been registered according to law and at the same time give the parents an opportunity to see exactly how the certificate was filled out. After examining the form, they will correct any errors or omissions they may find on the certificate and return it to the State Vital Statistics office. If the certificate is completely and correctly filled out, they will indicate this fact by signing and returning the form.

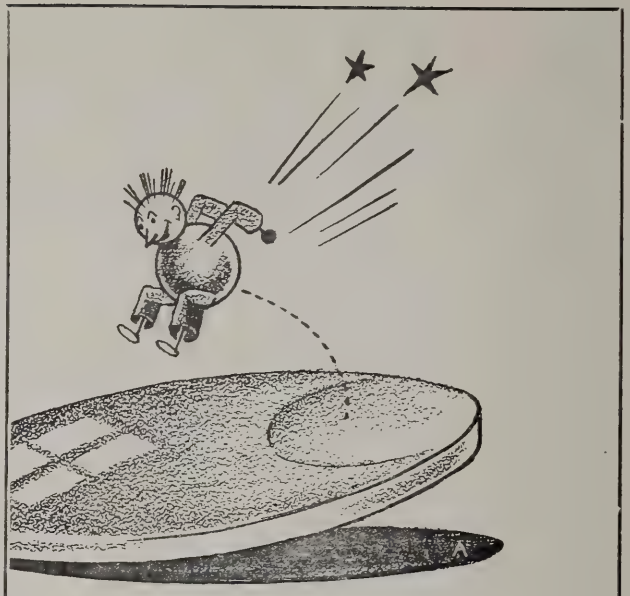
Those responsible for filing of birth certificates are being urged to see that they are complete and accurate. Special emphasis is placed on the necessity of making correct entries. Care should be taken to spell all names correctly; the date and place of birth should be given accurately.

Parran To Be Speaker

Dr. Thomas Parran, Surgeon General, United States Public Health Service, will speak on "The New Strategy Against V. D." at the Hotel Hollenden, Cleveland, at 12:15 P.M., February 5. The address will be the high light of a luncheon meeting sponsored by the Joint Social Hygiene Committee of the Cleveland Academy of Medicine and the Cleveland Health Council. Physicians may register with Dr. R. N. Hoyt, secretary of the committee, 1001 Huron Road, Cleveland, for the luncheon, and for the round table conferences on "Health Department Activities in V. D. Control" and "How to Answer the Questions of Youth", which will follow the luncheon.

Clinic To Observe Anniversary

The 25th Anniversary of the Cleveland Clinic will be observed February 24 to 27. The opening meeting will be held in the auditorium of the Cleveland Medical Library. A refresher course in treatment, consisting of a series of lectures and demonstrations will be conducted at the Clinic. Dr. E. N. Cowdry, St. Louis, will address a dinner meeting in connection with the course. His topic will be, "Precancerous Lesions".



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Do You Know - - -

The first blind person to serve on the Ohio Commission for the Blind was named recently by Governor Frank J. Lausche. He is the Rev. Daniel J. Uhlman, pastor of the Trinity Lutheran Church, Springfield. He succeeds the late Dr. Albert D. Frost, and his term will run to July 7, 1950.

* * *

Dr. Roger E. Heering, State Director of Health, has presented a proposal to Governor Frank Lausche for the removal of the administrative offices of the State Department of Health from the State Office Building to a new building which would be constructed as an additional unit to the Department's laboratory now located on the campus of Ohio State University, adjacent to University Hospital.

* * *

The American Red Cross has appointed D. Albert Hoffman, a veteran of World War II, state relations officer for Ohio, with offices in the State Capitol, Columbus. Following service as an infantryman, he was honorably discharged to serve with the Red Cross as a field director in the China-Burma-India Theater.

* * *

Dr. Albert B. Landrum, Columbus, has been grand secretary of Alpha Kappa Kappa for 30 years. Speakers at the fraternity's annual convention in Cleveland recently included Dr. Charles McKhann, professor of pediatrics at Western Reserve University School of Medicine. Dr. Howard T. Karsner, professor of pathology, Western Reserve University, was toastmaster at the banquet.

* * *

Two prominent members of the faculty of the University of Cincinnati College of Medicine are taking new posts on June 1. Dr. John A. Romano, professor of psychiatry, will join the staff of the University of Rochester School of Medicine, Rochester, N. Y., which recently received the Rivas bequest of $3,000,000 to be used exclusively in the development of psychiatry. Dr. Charles D. Aring, associate professor of neurology, will become professor of neurology and head of a newly-established department at the University of California School of Medicine, San Francisco.

* * *

Dr. Clyde Hissong, State Director of Education, has announced that all Ohio school bus drivers must take first aid courses and have American Red Cross certificates by Nov. 1, 1947.

* * *

"Uncle Sam, M.D.?", was the topic of an address made by George H. Saville, assistant executive secretary of the Ohio State Medical

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Association, at a meeting of the Springfield Rotary Club. He discussed President Truman's National Health Program, the Wagner-Murray-Dingell Bill and the program of the medical profession for improving the health of the American people.

* * *

Ohio State University College of Medicine has received a $10,000 grant for the study of leukemia, from the trust foundation set up by the late Commodore Louis P. Beaumont, Cleveland.

* * *

Sales tax receipts in Ohio for 1945 reached an all-time high of $69,461,659. Other collections under the sales tax law amounted to $6,318,-912 for a total of $75,780,571, a gain of $8,419,-310 over 1944, according to Don H. Ebright, Treasurer of State.

* * *

The National Foundation for Infantile Paralysis advanced nearly $1,500,000 in response to emergency requests from local chapters in 34 states during 1945. Ohio chapters received $17,039.75.

* * *

Dr. John H. Skavlem, Cincinnati, medical director of Dunham Hospital, has been elected a member of the executive committee of the National Tuberculosis Association. He is associate professor of medicine and director of the tuberculosis service at the University of Cincinnati College of Medicine, and president of the Mississippi Valley Trudeau Society.

* * *

Ohio State University College of Medicine is sponsoring a series of programs entitled "Keep Your Health", each Tuesday at 6:30 P.M. over WOSU.

* * *

Death claimed 4,015 physicians during 1945, as compared with 3,415 the previous year, according to the January 19 issue of *The Journal of the American Medical Association.*

* * *

Dr. Arthur M. Culler, formerly of Dayton, returned recently from duty as a captain in the Navy Medical Corps and has been appointed associate professor of ophthalmology at Ohio State University College of Medicine. He will be in charge of the college's postgraduate education and research in ophthalmology.

Dr. Ellis R. Bader, Cincinnati, is one of the vice-presidents of the American Roentgen Ray Society, which will hold its annual meeting at the Netherland-Plaza Hotel, Cincinnati, September 17-20.

* * *

Dr. Bernard H. Nichols has retired as roentgenologist at the Cleveland Clinic, a position which he held since 1921. He will continue as head of the X-ray Department at Robinson Memorial Hospital, Ravenna, where he has resided for many years.

* * *

Women comprise 62 per cent of all benefit recipients of Unemployment Compensation in Ohio.

* * *

The annual prize contest of the American Association of Obstetricians, Gynecologists, and Abdominal Surgeons Foundation will be conducted again this year according to Dr. James R. Bloss, secretary of the organization. Further information can be obtained by writing Dr. Bloss at 418—11th Street, Huntington 1, W. Va.

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The Physician's Bookshelf

Classic Descriptions of Disease, With Biographical Sketches of the Authors, by Ralph H. Major, M. D., ($6.50. *Charles C. Thomas Publ., Springfield, Ill.*) contains all the wealth of the popular first edition with new sections on Malaria and Yellow Fever as well as additional readings and illustrations. We can not all possess or even have access to the classic descriptions of disease, but we can all possess this handy and valuable collection.

Plaster of Paris Technique In the Treatment of Fractures and other Injuries, by Lt. Col. T. B. Quigley, M. C., AUS., ($3.50. *The Macmillan Co., New York City*) is a manual designed to help the surgeon and his assistants to acquire skill in the use of plaster of paris. Simplicity of presentation and 103 satisfactory illustrations make the book a success.

The Osseous System. A Handbook of Roentgen Diagnosis, by Vincent W. Archer, M. D., ($5.50. *The Year Book Publ., Inc., Chicago*) is one of the excellent series of such handbooks being brought forth by the publisher. The joints, the chest, the G. I. tract, the skull and sinus, and the urinary tract have already appeared. The book is successfully directed at the occasional radiographer. If you ever have occasion to take X-ray films of bones, then this little concise volume with 148 plates should be beside your viewbox.

Endurance of Young Men, ($2.50. Monograph Vol. X, Serial 40, No. 1 of the Society for Research in Child Development, *published by the Society, National Research Council, Washington 25, D. C.*) is the first statistical approach to kinesiology of the human body. With the oncoming emphasis on a physical fitness program such texts become of increasing worth.

Immuno-Catalysis, by M. G. Sevag, Ph. D., with a preface by Stuart Mudd, M. D., ($4.50 *Charles C. Thomas Publ., Springfield, Ill.*) brings much of value to all of us in terms that we can for the most part understand. It helps to break down the barriers of isolationism which in every phase of science is but an expression of limited understanding and immaturity. This work boils down and interprets for you and me more than a thousand publications in all languages and is not intelligible to us because of its specialized character. In this book, however, we discern that enzyme, substrate and specifically inhibitive reaction products have their corollary part in antigen, the antibody precursors, and specific antibodies. In fact the two are often not only analogous but actually identical.

Trichinosis, by Sylvester E. Gould, M. D., ($5.00. *Charles C. Thomas Publ., Springfield, Ill.*) is a book that each of us should study very carefully. It should be in your "must" list for your winter reading (one of the 24 days that you told Dr. Baketel you spend each year) for the disease is of surprisingly high frequency in this country. Because we often fail to recognize it, this volume is most valuable. Here for the first time is brought together all of the important and practical aspects of this disease.

General Biology and Philosophy of Organism, by Ralph Stayner Lillie, ($3.00. *University of Chicago Press, Chicago*) discusses the philosophical problems of biology, or the interaction of the physical and the psychical. Its author is the distinguished professor emeritus of General Physiology at the University of Chicago. Much more worthwhile than the psycho-soma's current literatim.

Manual of Public Health Hygiene, by J. R. Currie, M. D., and A. G. Mearns, M. D., ($6.00. 2nd Ed. *A William Wood Book, Williams & Wilkins Co., Baltimore*) is a useful Scotish manual on public health.

Prescribing Occupational Therapy, by William Rush Dunton, Jr., M. D., ($2.50. 2nd Ed. *Charles C. Thomas, Publ., Springfield, Ill.*) has been brought up to date by adding an excellent chapter on rehabilitation.

Hahnemann: The Adventurous Career of a Medical Rebel, by Martin Gumpert, M. D., ($3.00. *L. B. Fischer Publ. Corp., New York City*) is a study of an unusual character who would have been a great rebel in any era and in any profession. It is the medical advisor of Time interpreting the rise of Homeopaltry.

Diseases of the Nose, Throat and Ear, by Chevalier Jackson, M. D., and Chevalier L. Jackson, M. D., with the collaboration of 64 outstanding authorities, ($10.00. *W. B. Saunders Co., Philadelphia*) is designed along conventional lines as a practical text for all authors who are known as excellent teachers but who also have had an active part in the epoch-making developments of recent years.

The Story Behind Great Medical Discoveries, by Elizabeth R. Montgomery, ($2.00. *Robert M. McBride & Co., New York City*) is one of the newest selections of the Junior Literary Guild and every youngster who is interested in science, medicine, or nursing should have a copy of this lively book of tales which humanizes the march of medicine.

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JONATHAN FORMAN, M.D., *Editor*

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The Closure of Débrided War Wounds

GILMAN D. KIRK, M.D., and MAURICE A. HERSHEY, M.D.

SECONDARY closure of a débrided wound is not a new problem but the treatment of war wounds has given new incentive to its study. The results obtained in a recent series are presented.

As virtually all war wounds are now adequately débrided in the first few hours after injury, an effort should be promptly made to eliminate the tissue defect of the débridement. In this report "early" closure is arbitrarily applied to those wounds closed within the first seven days from time of wounding. "Convalescent" closures are those closed from the eighth to the thirtieth day, and "late" closures are those done after thirty days.

The first thing to consider in secondary wound closure is which type should be closed and when. The answer depends on many factors: The type, extent, location, number, depth, the previous treatment, and the associated injuries; all these influence the surgeon's decision. In this series all the cases had the excellent early treatment of adequate and complete débridement.

The depth of the wound is an important factor. A piece of shrapnel may make a small puncture wound in the skin and lodge deep in the muscle. At the time of débridement it is surprising to see how much torn and macerated muscle may lie in the path of the shrapnel. A deep wound is thus established which will require secondary closure. If there are no clinical signs of infection and there is only a slight amount of clean smelling serous discharge, these deep wounds may be closed with impunity.

The location has also these factors to consider. The more subcutaneous tissue there is present the better will be the closure. Wounds close to bones, especially the lower third of the leg, and around such joints as the ankle, knee, and elbow are difficult to close and tend to break open before healing is complete. The palm of the hand and the sole of the foot are notoriously difficult to close. Wounds of the buttock were naturally a matter of concern because of their contamination. Closure of deep wounds of the buttock was at first discouraged but with careful preoperative preparation it was found that they could be closed without infection and that good healing would occur.

Many patients were admitted with other severe injuries which precluded doing an early closure. A patient who has had a laparotomy and a colostomy may well not be in a favorable

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The Authors

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● Dr. Hershey, Buffalo, New York, is a graduate of Queen's University Faculty of Medicine, Kingston, Ontario, 1933; Maj., Med. Corps, A.U.S., asst. chief of surgery, 53rd General Hospital.



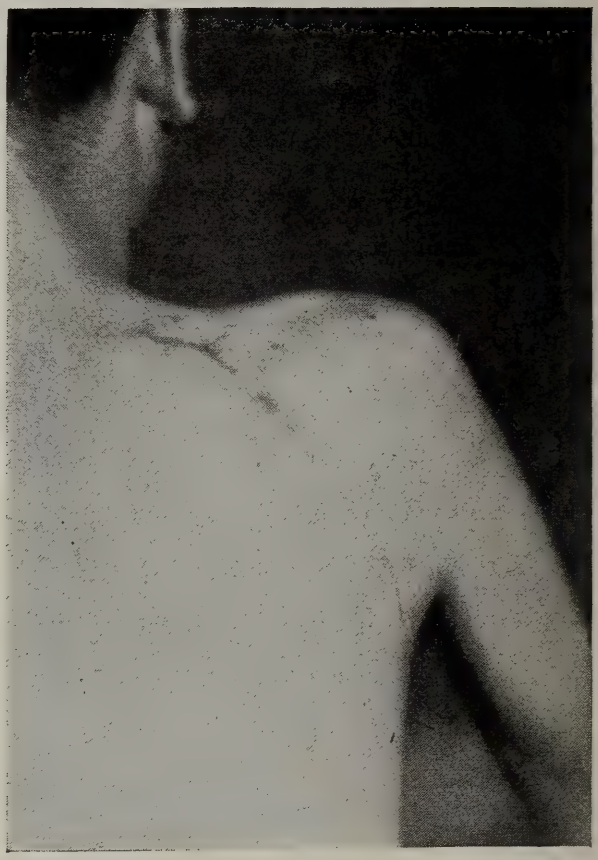
Case I-A: Abdominal wound two weeks after wounding. The débridement went down to the deep fascia of the abdominal wall. A secondary closure was done the day after this picture was taken.



Case I-B: Abdominal wound two weeks after secondary closure showing healing by first intention.



Case II-A: Deep wound of the right shoulder two weeks after extensive débridement.

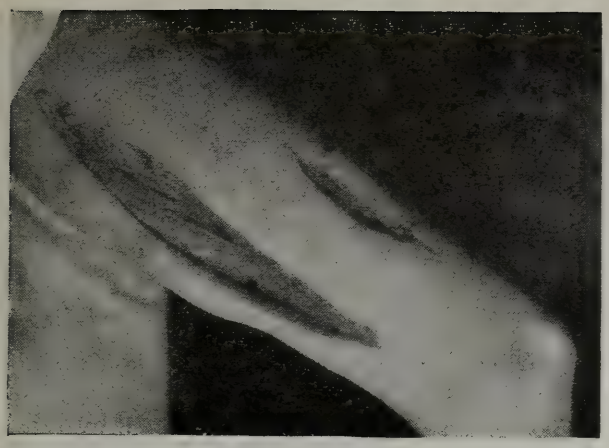


Case II-B: Shoulder wound one month after secondary closure. Besides the severance of muscles there was a fracture of the spinous process of the scapula which did not interfere with healing of the secondary closure.

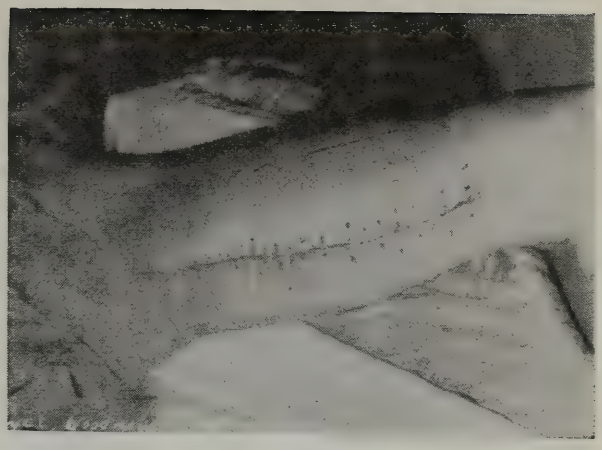
condition for a closure of an associated wound in the thigh. He has had enough psychological and physical insults without adding another that may seem minor to the surgeon but which looms and is large to the patient. Usually a week or so of rest and physiological readjustment is well spent as it allows him to get acquainted with the personnel of the ward and brings him into sufficiently good condition so that wound closure at that time becomes justifiable.

The same situation exists in a patient who has had a compound comminuted fracture of the tibia and fibula as well as multiple small wounds along the leg and thigh. The fracture and wounds have been adequately débrided, the bone fragments are in good condition, a long leg cast is on and the patient is comfortable. Such a patient will do well to be left alone until there is some reason to change his cast at which time the wounds can be cleansed and closed and the leg recast.

Another typical problem is that of the patient with a compound fracture of the femur. He is put up in skeletal traction and the fragments brought into good alignment. Within a week or more after he has been put in traction his



Case III-A: Two thigh wounds taken three weeks after débridement. Azochloramide dressings, adhesive bridges, and elastive bandages reduced the width of these wounds and the edema to the condition shown. The wounds are clean, there is no infection, and they are ready for closure.



Case III-B: This picture was taken three weeks after secondary closure. Healing is complete.



Case IV-A: This is a picture of the medial surface of the thigh taken four weeks after wounding. Closure was not attempted sooner because of other complicating wounds including a compound fracture of the humerus, a partial amputation of one hand, a urethral injury, bilateral orchidectomy, and other wounds of both lower extremities.



Case IV-B: This picture shows thigh wounds four weeks after secondary closure. The skin edges were excised, the granulating base cut down to a greyish pink base, and the skin edges undercut and brought into approximation. This demonstrates how a wide wound may be prepared and undercut sufficiently to close without requiring a skin graft.

wounds may be ready for closure. It is inadvisable at this time to move him to the operating room and chance the loss of bony position. As a result, except in certain selected cases, the wound closure is postponed until the sixth or seventh week when fixation of the fragments has occurred.

One of the major reasons for wound closures is to speed his convalescence so that the patient may be returned to duty in a minimum of time. It has been our policy to make closures in suitable cases as quickly as possible and to give them a priority on professional service. Other patients will not have their period of hospitalization affected one way or the other by a wound closure, and are therefore treated at what is, in our opinion, the most judicious time. Nearly all fracture cases will not have firm bony union for many weeks, long after the soft tissue wounds have been closed and healed.

No attempt has been made to study the type of missile causing the wounds. Mortar fire and 88 mm. shells were the most frequent agents. Shrapnel from these and other types of weapons tear their way through tissue whereas a bullet has a spinning motion and makes a cleaner type of perforating wound.

The time of admission is naturally an important factor but is one over which we had no control. Many of our battle casualties were admitted to the hospital anywhere from four to twelve days after injury. It is of course impossible to do an "early" closure on a patient admitted on his twelfth day.

There is a certain small per cent of clean wounds with no necrosis or infection that can be closed loosely at once. These are usually the small superficial type which after débridement leave an elliptical wound involving the skin and subcutaneous tissue. However, in the majority of our cases it seemed advisable to prepare them for closure. This was done in a rather standard way by applying warm wet saline dressings for 48 hours before the closure. In wounds that seemed to require several days of preparation either wet dressings or azochloramide in oil



Case V-A and B: This is an A.-P. and lateral of a débrided shoulder wound taken several days after wounding.

was used. The latter seems effective in cleaning a wound and requires fewer changes of dressings and less nursing care.

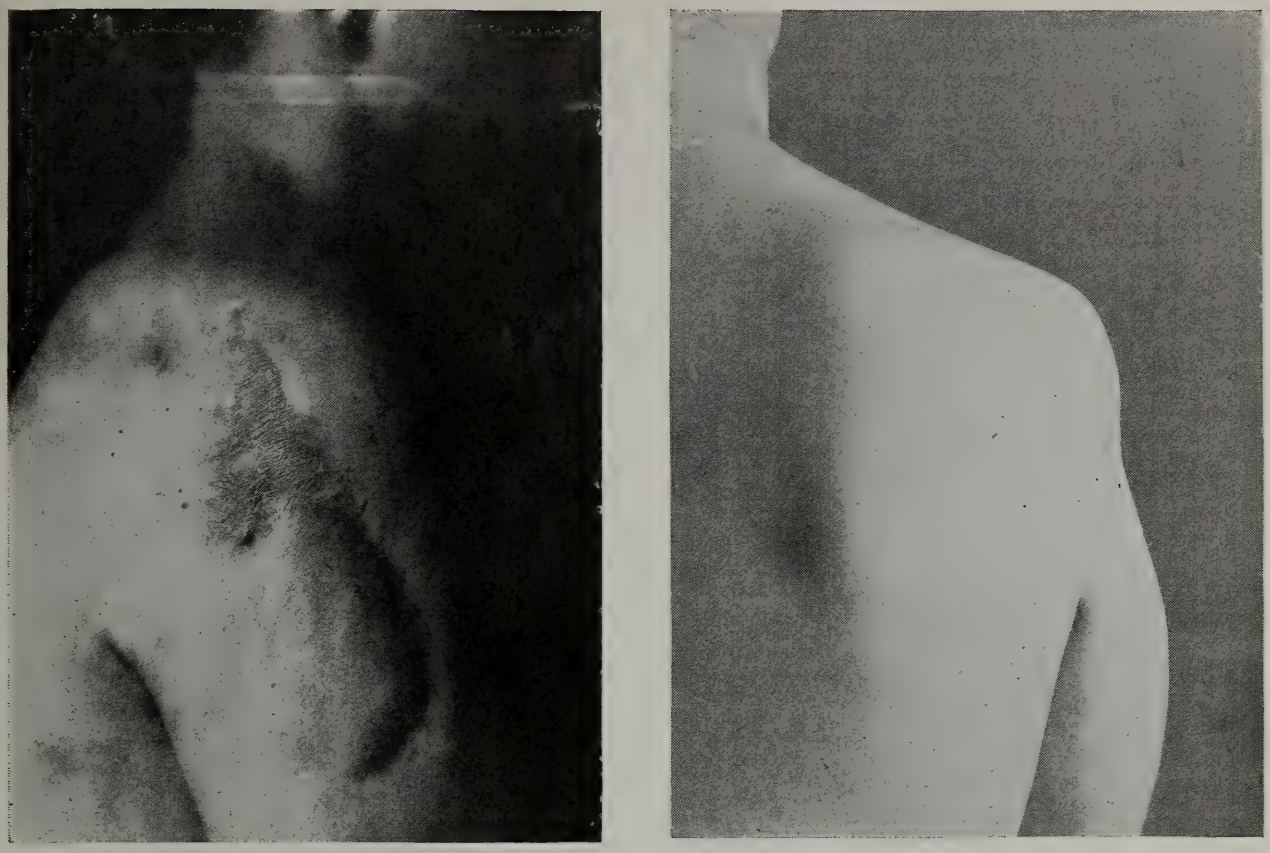
Another very important step was to support the wound and to overcome the boggy edematous edges with either adhesive bridges or elastic bandages. After débridement the wound swells and the surrounding tissues become edematous and boggy making the wound wider and deeper. A few days of bed rest, elevation of the extremity, adhesive bridges, and snug circular bandages will decrease the edema of the wound and make it much more amenable to closure. It is still a source of surprise to see how big a wound can be approximated with this type of careful preparation. Indeed, many small wounds have been completely closed without any surgery at all by this type of approximating pressure. Case III illustrates these principles.

There were many cases in which the skin defect was too large to completely close so that a split skin graft had to be used to complete the operation. Although very few such cases are included in this series, Case V and Case VI are examples of this procedure. The split skin was applied at the same time as the wound closure and a high percentage of "takes" resulted. The application of a skin graft eliminated the error of trying to close a wide defect by using excessive tension on the skin edges.

OPERATIVE TECHNIQUE

The standard procedure was as follows. The wound was shaved around its edges, washed with soap and water, ether, then alcohol, and an antiseptic dye applied to the skin. The wound was then draped. The devitalized skin edges were excised to normal skin area. The wound edges have then usually retracted and a considerably larger area of denuded surface was present than when the operation started. The granulations were scraped off to the base of the wound with a scalpel and if thick scar tissue was present beneath them the scar was excised so that a thin pliable layer was left with a greyish pink color and multiple tiny bleeding spots. A hot sponge was then applied to control oozing and any large bleeders were ligated with fine catgut.

It is desirable that a minimum of foreign matter such as ligatures be left in the wound but hemorrhage must be controlled. The wound edges were undercut to any degree necessary to bring the edges into approximation without tension. The skin itself was closed with any suitable material such as silk or nylon and usually with interrupted mattress sutures. Nylon tension sutures were placed when necessary. The wound was then dressed with xeroform or vaseline gauze, 4x4 dressings, and either an abdominal pad or mechanic's waste to maintain adequate pressure and to avoid dead spaces. The use of drains was limited to large wounds, deep wounds, or those in which there was danger of pocketing of serum or blood. Drains were removed in 24



Case V-C and D: These pictures show the wound four weeks after secondary enclosure. The upper third of the wound was closed with a skin graft. Shoulder motion was good but abduction was limited.

or 48 hours. The type of drain was always a split Penrose rubber drain.

ANAESTHESIA

The anaesthetic used depended on the extent of the wound, its anatomical location, and the condition of the patient. Many were done under local, 1 or 2 per cent novocaine, many under sodium pentothal, and a certain selected number under spinal anaesthetic. The latter was used in multiple wounds of the lower extremity and particularly in those associated with fractures. All pentothal anesthesias were supplemented with oxygen therapy.

CHEMOTHERAPY

In this series at this hospital it was decided to treat all wound closures the same way as regards chemotherapy. Other hospitals chose to use more intensive chemotherapy but the results statistically was essentially the same as those obtained here. No patient received preoperative sulfonamides or penicillin at this hospital. Many patients had received one or both in the forward medical echelons but the records were such that it was very difficult to determine with any degree of accuracy just how much chemotherapy any patient had received. Many patients received 20,000 to 60,000 units of penicillin soon after injury. They also received a small amount of sulfonamides. However by the time they had arrived here it had usually been discontinued. Such treatment was re-instituted if there was any reason to do so. There was a certain number who had received large amounts of chemotherapy previous to admission because of severe injuries and infection.

At the time of wound closure all wounds were dusted lightly with sulfanilamide crystals. Penicillin was not used locally. Postoperatively no patient received chemotherapy unless there were signs of infection. If so they received at the ward officer's discretion either sulfonamides or penicillin or both according to the indications. All infections that did occur were localized. There was no case of septicemia, and no case had more than a localized cellulitis. In case of infection stitches were removed from the wound and hot packs applied. Chemotherapy was instituted parenterally and orally if there was any indication that the infection was out of immediate control. Local infection around the stitches was usually due to excessive tension. This could be partly controlled by reapplication of bandages and bridges.

POSTOPERATIVE CARE

Postoperative care consisted of leaving the dressings alone for about five days unless otherwise indicated. Sutures were not removed until 10 to 12 days had elapsed. If there seemed to be undue tension even though the wound was healed adhesive bridges were continued for another



Case VI-A: This is a picture of the lateral surface of the thigh taken one month after injury. There was a supracondylar fracture of the femur and an amputation below the knee in this leg.



Case VI-B: This picture shows a partial wound closure at time of operation. Note that the skin is not under any particular tension.

week. If the wound was extensive it was often supported with padded wire splints. Joint motion was eliminated if it might cause motion enough to unduly increase the tension.

RESULTS

The purpose of wound closure was twofold. First, to make a clean, closed wound out of an open, potentially infected one. Second, to decrease the time of hospitalization and thus expedite the patient's return to duty or his transfer to the Zone of the Interior.

In regard to the latter purpose it may be said that there were a large percentage of patients who were so involved with other injuries of a more serious nature, particularly fractures, that wound closures did not affect their hospitalization.

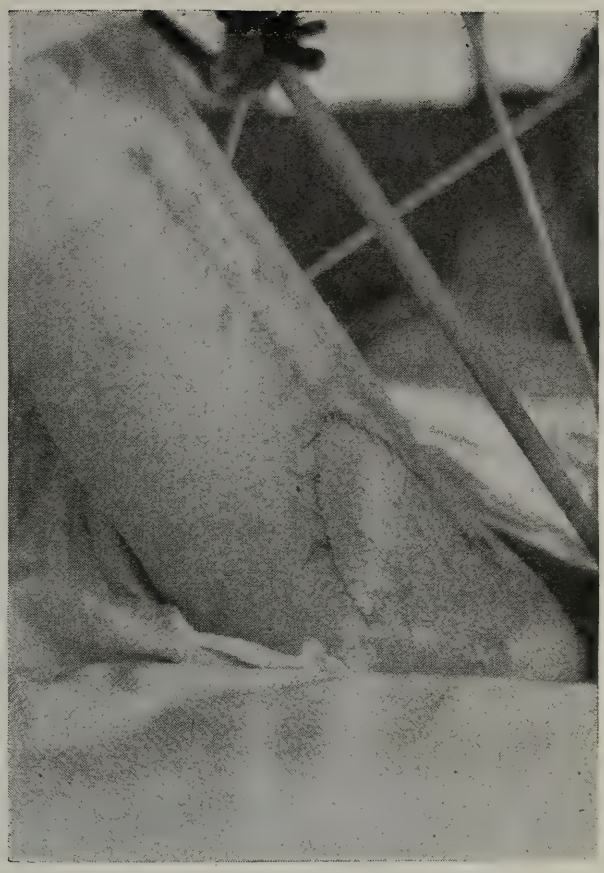
A number of patients had so much tissue loss, including muscle, as well as contracture from scar at the site of wound closure that they had to undergo lengthy physiotherapy and rehabilitation before being fit for duty. This scarring occurred in spite of adequate splinting during the healing period. A common example of this were wounds of the calf of the leg. Even with the foot supported in hyperflexion after the patient began to walk there would be further contractures in the calf muscles so that he had difficulty and pain in trying to maintain a normal walking gait. Wounds in the axillary region were prone to result in some limitation of abduction of the shoulder. It was necessary at a later date to excise some of these scars to provide a more normal range of motion. In selected cases recovery followed more quickly the excision of the scar than waiting until exercise had stretched out the scar.

A number of patients had wounds reopen after they were apparently well healed. This was most common in the leg especially in the lower half. On becoming ambulatory walking as well as sometimes edema of the ankle caused the wound to break down so that the patient had to be put back to bed. This was a factor that could only be tested by making the patient ambulatory, but as a result they were hospitalized much longer than was originally anticipated.

Others had a scar over areas subject to trauma and in their cases normal activity was delayed. For example, one abdominal scar fell directly under the patient's trouser belt and this patient was unable to keep a tight belt until the scar had become older and tougher. Case I illustrates this point. The same difficulty existed for certain wounds of the shoulder and back which made it painful for the soldier to carry a pack. Case II is an example of this condition. Buttocks wounds over the ischial tuberosity are subject



Case VI-C: This picture shows the upper half of the wound with skin graft in place at completion of operation.



Case VI-D: This picture shows the wound two weeks after operation. The closure is healed. The skin graft has taken completely. A careful closure was essential for this patient because of the necessity for wearing an artificial limb at a later date.

to repeated and painful trauma of the scar. Case IV is illustrative of this.

There was always a certain number of patients who had vague complaints who did not respond to rehabilitation, complained of pain in the wound site, of weakness and bizarre pains. These were extremely difficult to evaluate in all honesty to the patient. Such a patient was given all possible consideration before a final decision as to disposition was made. We may safely assume, however, that some of these who were returned to duty promptly found their way back into the medical lines of evacuation.

There were 341 patients in this series and the total number of their wounds was 400.

The size of the wounds varied, the largest one in this series being 12 inches long and 5 inches wide. The average size at time of closure was 3½ inches in length and 1¾ inches in width. This calculation of average sizes gives a distinctly false impression. The size varied from day to day as the edema and swelling subsided the size of the wound also decreased. Most of the measurements were made just prior to wound closure when the wound was in an optimum condition and with preoperative care had been reduced to a minimum in size.

During the preoperative period the subsidence of edema by pressure dressings, the normal healing activity, and the muscle atrophy reduced the size of wounds as much as 50 per cent. The irregular contour of the wounds made it difficult to give an accurate idea of their area and no measurement was made of the depth. Furthermore after excision and undercutting of the edges prior to closure it was usually considerably larger than it was when measured for size preoperatively.

The location of wounds was as follows:

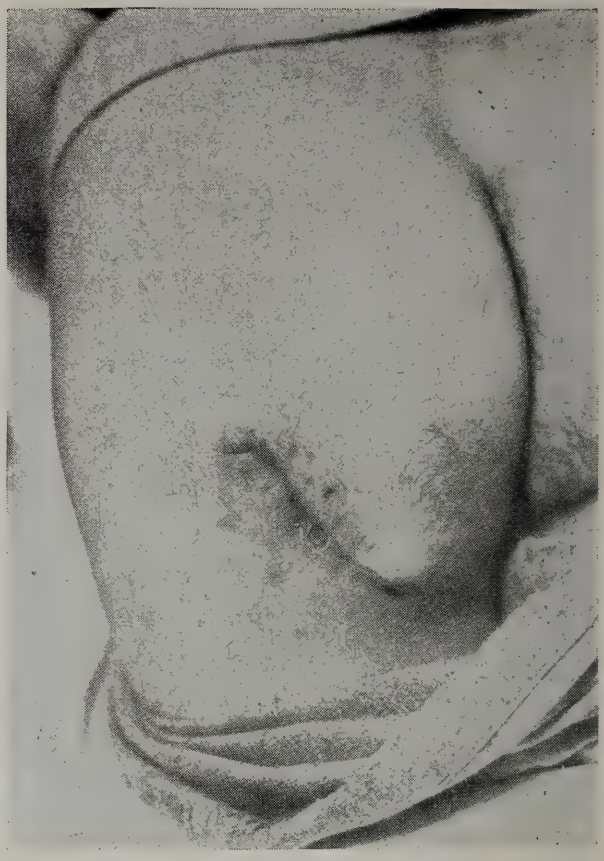
Head and neck	6	1.5%
Chest	18	4.5%
Abdomen	9	2.3%
Back	49	12.2%
Arm and forearm	63	15.8%
Buttock	36	9.0%
Thigh	122	30.5%
Leg	97	24.2%
Total	400	100%

The high preponderance of injuries to the lower extremity is evidenced by the following statistics:

Head and neck	6	1.5%
Upper extremity	63	15.8%
Body	76	19.0%
Lower extremity	255	63.7%
Total	400	100%



Case VII-A: This picture shows a circular wound of the buttock which was allowed to granulate in for three weeks after wounding and débridement.



Case VII-B: The circular wound was closed by undercutting the edges and approximating them. This is the wound three weeks after closure and shows a small area in the center which is still open. A skin graft in this area is difficult to dress and keep clean.

Although practically all cases were débrided before admission here the records show the actual time of débridement on 150 cases only. The average time was 1.4 days from injury to débridement, according to available figures.

As previously stated, secondary closures were arbitrarily divided into three classifications. There were 345 wounds on whom the time of secondary closure was accurately known.

From 1 to 7 days—	7 wounds—	av. 6 days
From 8 to 30 days—	298 wounds—	av. 19 days
From 30 days on —	40 wounds—	av. 40 days
Total	345 wounds.	

Attempts to analyze the use of penicillin are difficult. The records are inaccurate and the patient himself could not help much. An analysis of the records showed 134 cases to have received penicillin:

A further analysis of infections in the closures revealed that of the 400 cases, irrespective of early chemotherapy, the following results were obtained:

Number of infections:

Slight	—41 cases—	10.3%
Moderate	—11 cases—	2.7%
Severe	— 0 cases—	0.0%
Total	52 cases—	13.0%
No infection:	348 cases—	87.0%

SUMMARY

1. There were 341 cases with 400 wounds.
2. The average size of the wounds was 3½ x 1¾ inches, the largest being 12 x 5 inches.
3. The majority were closed on an average of 19 days from time of wounding.
4. In 400 wound closures 52 wounds or 13

Penicillin	Infections				No Infection	
	No. Cases	mild	mod.	Per Cent	No.	Per Cent
Under 100,000 units	70	11	2	9.7	57	42.5
Over 100,000 units	64	5	1	4.5	58	43.3
Total	134	16	3	14.2	115	85.8

per cent had slight to moderate infection.

5. Primary union resulted in 362 wounds or 90.5 per cent of the cases. Healing with a widened scar resulted in 26 cases or 6.5 per cent.
6. Mild infection did not necessarily affect the end result as 27 cases or 6.8 per cent had mild infection with good healing.
7. All cases with moderate infection, 11 cases or 2.7 per cent, gave a poor result.

CONCLUSION

Secondary closures are a safe and practicable procedure which speeds the convalescence of the patient and improves his morale. Successful closure depends on adequate early débridement, the careful clinical selection of time for closure, and the necessity for a minimum of tension on the skin edges. The excellent physical condition of the patients and selective chemotherapy are both important factors in wound healing. Finally the actual closure of war wounds is only one small step in the complicated process of restoring a man to the degree of physical and emotional stamina necessary to make him once more a combat member of the fighting forces of the United States Army.

REFERENCES

1. MacPherson, A. I. S.: Delayed Suture of Soft Tissue Wounds. Lancet 2:43, July 8, 1944.
2. Sarjeant, T. R., and Morton, W. A.: Delayed Suture of Soft Tissue Wounds. Lancet 2:333, Sept. 9, 1944.
3. Wilson, Harwell, and Threadgill, Francis D.: Secondary Suture of War Wounds. Bull. of the U. S. Army Med. Dept. Vol. 82:77, Nov., 1944.
4. Whelan, C. S., and Thompson, W. D.: Skin Grafting and Secondary Closure in War Wounds. Surg. Gyn. and Obst. Vol. 79, No. 6:584, Dec., 1944.
5. Wilson, Harwell: Secondary Suture of War Wounds. Annals of Surgery Vol. 121, No. 2:152, Feb., 1945.

Frozen Foods

The loss of nutrients has been studied in blanching, freezing, storage, and cooking. The freezing process retains more nutritive value than any other method of preservation. The losses during storage of frozen products are small. The blanching and cooling prior to freezing vegetables, however, result in a considerable loss of vitamin C and significant losses of some of the other vitamins and water-soluble minerals. Because frozen foods require much less cooking than fresh products, the loss of nutrients from cooking is considerably less. The net result is that frozen foods may have a high a nutritive value when they reach the table as they do when cooked fresh. For example, frozen peas cooked after a year's storage may have as much vitamin C as the same product cooked within seventy-two hours after picking.—Editorial, N. Y. State Jr. Med., Vol. 46, No. 2, Jan. 15, 1946.

KEEPING UP WITH MEDICINE

SEVENTY-FIVE per cent of reported occupational disease cases are due to skin irritants.

* * *

SINCE most nuts contain at least 50 per cent fat, they may be used to make up for the scarcity of shortening.

* * *

IF it is necessary to make the food money go the farthest, recent studies in Cincinnati show that of 20 vegetables ordinarily offered on the market the most advantageous to purchase were cabbage, potatoes, squash, and onions for mineral and vitamin content in terms of cost.

* * *

WE are coming to know more about cobalt as an essential trace mineral.

* * *

REDUCING noise in the home would add much to its comfort and take a great load off the nervous systems of many persons.

* * *

CIRRHOSIS of the liver with ascites is reported as responding to treatment with choline and cystine in those patients with large livers.

* * *

AROUND 15 per cent of our people are said to be harboring amebae. A recent X-ray finding in these individuals is cecal deformity without involvement of the terminal ileum.

* * *

WE give vitamin B_1 the most frequently when we suspect a deficiency yet a recent study of city children showed that most deficiencies were due to a lack of A and next riboflavin. All surveys of rural people show that vitamin C is the one most frequently deficient.

* * *

THE Federal Government has just arranged to subsidize the foreign coffee grower in order to keep the price down. So we have the paradox of spending millions on health while we also spend millions to promote the sale of a useless commodity which in some cases produces insomnia and nervousness.

* * *

A GENERATION ago there were five cases of coronary thrombosis in the male to one in the female. Today the ratio is two to one. Something has happened to our women!

* * *

OUR society must not drift to a situation in which men and women past sixty are a burden. We need everyone contributing his effort and experience with alert and strong mental and physical faculties.—J.F.

Psoriasis: A Therapeutic Review

IRVING L. SCHONBERG, M.D.

ORMSBY[1] states that psoriasis comprises 4 per cent of all cutaneous disease reported in this country. Gahan[2] has estimated that one white person in every hundred has psoriasis. Pollitzer in an analysis of 676,376 cases reports 2.8 per cent cases of psoriasis. Bereston and Ceccalini[4] found that psoriasis ranks second as the most common skin disease in the examination of 20,000 inductees and that generalized psoriasis was the most common cause for rejection. In about 7,000 dermatologic cases seen at this hospital there were 207 cases of psoriasis, (2.9 per cent).

Many of the psoriatics upon entrance into the service present transient scaly areas on the elbows, knees, or scalp. At variable periods of time these so called mild cases become severe. The individual lesions enlarge become thickened and new areas appear on parts of the body never before involved. There is no doubt that individuals with mild aberrant types of psoriasis and those with psoriatic diatheses may develop exacerbations following entrance into the service. However, the same course of events would follow in civilian life. It is problematical whether these changes occur as a result of diet, climatic changes, or whether emotional factors and the rigors of army life contribute to the exacerbations.

The evaluation of therapeutic measures in a disease such as psoriasis is a most difficult procedure. Dermatological literature abounds with hundreds of medications and regimes employed in treating this most discouraging of dermatoses. Etiologically we know no more about psoriasis now than we did 100 years ago. Various measures such as parenteral and enteral medications have been moderately successful in the hands of some enthusiasts. However, after a thorough trial by the dermatologic profession, most of these are eventually buried in the archives.

Over 200 cases of psoriasis were seen in the Dermatologic Clinic. From these, 35 cases of severe character were admitted to the hospital for observation and treatment. Various acceptable methods of therapy were employed. Due consideration was given to the spontaneous remission factor.

Hospitalization was deemed advisable for the following reasons:

1. No therapeutic response to the usual methods of ambulant therapy.
2. Mental depression resulting from the unsightliness of the disorder.
3. Uncontrollable subjective symptoms such as itching and burning of intertriginous areas.
4. Admissions for disposition.

Submitted October 5, 1945.

The Author

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All but two cases were psoriasis vulgaris, the other two being of the guttate variety. The cases were studied from the following standpoints: (1) Family history; (2) duration; (3) probable cause, as explained by the patient; (4) past treatment; (5) associated symptoms; (6) dietary effect; (7) climatic effect; (8) present treatment.

1. Family history. In a series of 35 cases, eight patients gave a history of psoriasis in the immediate family. In five of these, either the father or the mother had the disease and in three, a sister or brother. The patients were also questioned regarding other familial diseases, particularly arthritis. In three of these, there were histories of arthritis in the immediate family.

2. Duration. The cases varied in duration from two years to 15 years.

3. Probable cause. The stated cause in a number of cases was as a result of the patient's own experience. In two cases, psoriasis developed following innoculations for typhoid and tetanus. In two cases there was a history of severe anxiety or shock. Two patients developed psoriasis following injury in an auto accident. The remaining 29 had no idea as to the possible etiologic factors.

4. Past treatment. The patients were interrogated regarding the treatment that they had received in civilian life. Many of them had received the usual emolients such as chrysarobin, tar, and the various types of physical therapy as X-ray and ultra-violet.

5. Associated symptoms. One patient gave a history of gonorrhea, with gonorrheal arthritis. With the exception of this one case, there were no associated symptoms.

6. Dietary effect. According to the patient's history, diet played a part in the aggravation of psoriasis. One patient stated that large amounts of alcohol precipitated an attack. In the majority of cases, however, fat seemed to be the provoking factor.

7. Climatic effect. Twenty-two patients stated that their psoriasis was better in summer. Two patients stated that it was worse in summer, and in the remainder, climate had no effect upon their condition. It was particularly noted that patients from the northern part of the country were improved when they came to the southern part. Patients from the south were unaffected by climatic change.

8. Present therapy. All cases were given the benefit of indicated laboratory examination. These included blood chemistries, blood counts, basal metabolisms, and X-rays were indicated. No notable abnormalities were found. These findings have been brought out by previous investigators.

Internally:

(a) Vitamins, B, A, D.
(b) Bismuth and arsenic.
(c) Salicylates.
(d) Diet: Low fat, low protein.
(e) Autohemotherapy.

Externally:

(a) Soap suds soak.
(b) Ammoniated mercury ointment 5 per cent, 10 per cent.
(c) Ammoniated mercury 5 per cent, salicylic 3 per cent, ointment.
(d) Oil of Cade 5 per cent, salicylic 3 per cent, ointment.
(e) Chrysarobin 1 per cent, 3 per cent, 5 per cent, ointments.
(f) Sulfur 8 per cent, salicylic 4 per cent, ointment.
(g) Crude coal tar ointment 5 per cent.
(h) Ultra-violet and X-ray.

SUMMARY

Parenteral and enteral medication of all types were of no apparent value in this series.

Exacerbations were most prevalent where infiltrated patches remained. Recurrences took place within 3 to 4 weeks, after discharge from the hospital.

Dietary measures were of questionable value.

Auto hemotherapy seemed to benefit only the acute guttate variety.

Genital and intertriginous, nail and scalp lesions were most resistant to therapy. Nail lesions did not respond to any measures.

Although there was some evidence of familial tendency in several of the cases no definite conclusions could be drawn.

CONCLUSIONS

Under the best conditions, certain cases of psoriasis will not be influenced by therapy of any type.

Long standing infiltrated lesions are most resistant to therapy.

Psoriasis should be treated until completely cleared if possible.

The best method of therapy is external. A soap suds soak and keratolytic preparations were employed for the first few days of treatment. This was followed by a 5 per cent crude coal tar ointment in conjunction with ultraviolet as suggested by Goeckerman.[5] Residual lesions were treated with 1 to 3 per cent chrysarobin and ultra-violet.

BIBLIOGRAPHY

1. Ormsby and Montgomery: Disease of the Skin. 10th Ed.

2. Gahan, Emanuel: Incidence of Psoriasis Among the Population at Large. Arch. of Derm. and Syph., 18:3, Sept., 1943, p. 305.

3. Goodman, H.: Statistics of Ten Most Common Skin Diseases, Based on Analysis of 973,090 Published Cases. Arch. Derm. and Syph., 20:186, August, 1929.

4. Bereston, Eugene S., and Ceccolini, Edward M.: Incidence of Dermatosis in Seventy Thousand Army Induction Examinations. Arch. of Derm. and Syph., 47:6, June, 1943, pp. 844-848.

5. Goeckerman, W. H.: Observation on Use of Crude Coal Tar and Uultra-violet Light. Arch. of Derm. and Syph., 24:440-450, Sept., 1931.

Edema In Diabetes

The literature which we have reviewed shows no clearly defined clinical picture associated with all cases of intercapillary glomerulosclerosis; however, in the most advanced cases there is a tendency to proteinuria and a hypoproteinemia. A relatively small number of these manifest a nephrotic syndrome. In the others the important clinical features are cerebral vascular accidents, cardiac failure, uremia or peripheral vascular arteriosclerosis. The clinical criteria which have been correlated with advanced intercapillary glomerulosclerosis are: (1) The patient is usually 40 years of age, and more often a female; (2) the diabetes is mild, requiring little or no insulin; (3) varying amounts of protein in the urine; (4) hypoproteinemia is usually found; (5) arteriosclerosis is present; (6) hypertension is frequently found but may be absent; (7) retinal vascular sclerosis is common; (8) varying degrees of renal insufficiency are present; (9) varying degrees of cardiac failure, usually of the left ventricle, are found; (10) in a few, there is evidence of marked generalized edema.—E. J. Lefeber, M.D., and George M. Decherd, Jr., M.D., Galveston, Texas; Texas State Jr. of Med., Vol. XLI, No. 10, Feb., 1946.

Prophylaxis Against Venereal Disease

HARRY WAIN, M.D.

MEN and women who indulge in promiscuous sexual relations sooner or later become infected with a venereal disease in spite of every precaution. The surest way to avoid a venereal disease is not to have sex contacts outside of marriage. However, human nature and public morality being what it is, it is a well-known fact that this advice has not been followed by a large percentage of the population in the past, nor is it likely to be in the near future.

No method has as yet been invented which will prevent gonorrhea or syphilis. Many infections can be prevented by certain prophylactic measures, used before and after sexual exposure. Prophylactic measures are perhaps our strongest weapons of defense, yet widespread dissemination of information and mass education concerning them have not been carried out because of prudery. Many well meaning people still believe that the widespread dissemination of information on prophylactic measures is in direct conflict with our standards of public morality. There is still a strong feeling that to abandon reticence in these problems will serve to undermine our public morality, which is already bad.

It is problematical whether, even if methods of safety could be guaranteed, that the number of people whom Venus irresistibly lures would be materially increased over the present staggering and statistically indeterminable number.

It may be safely said that prophylaxis is not so efficient as to justify any one in assuming any risk of infection and counting upon its use to compensate for lack of self-control, but it is sufficiently effective to warrant its employment in the most thorough manner. Army statistics show that one venereal infection in 30 sexual exposures occurs when no prophylaxis is used, but when prophylaxis is used only one infection in 90 sexual exposures occurs. It becomes a question then, easy to answer: "Is it more moral or less moral to keep such information from being disseminated?"

METHODS

Prophylaxis consists of two types: (1) The mechanical method, which consists of using the condom; and (2) chemical methods, which involve various means of disinfection ranging from prompt washing of the genitals with soap and water to the thorough use of various drugs and chemicals. The best prophylactic technique consists of using a condom during the sex act and chemicals after the act. The condom protects both the man and the woman. Chemicals by and large are only effective for the man. The condom acts as a shield which keeps the germs from being passed from one person to another. It is safer, therefore, to rely on the condom first and use chemicals afterward as an added precaution.

Submitted November 19, 1945.

The Author

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GONORRHEA

Gonorrhea being a disease as ancient as mankind, it is to be expected that prophylaxis against it should be among our earliest medical records. In the Ebers Papyrus which was probably written about 1500 B.C., we find the ancient Egyptians stating that the female genitalia could be protected against the entry of disease by injecting a douche which contained garlic and the horns of a cow as ingredients. Was this disease, which entered the vagina and against which the Egyptians attempted prophylaxis, gonorrhea? If so, we have here the first attempt at the prophylactic prevention of a venereal disease. Evidently, the precaution was not always successful because the Papyrus informs us that should this prophylactic fail and inflammation ensue, the nature of the douche should be changed to one of bile of the cow, cassia, and oil.

Moses in the fifteenth chapter of Leviticus advocates prophylaxis against gonorrhea as follaws: ". . . And he that touchest the flesh of him that hath the issue shall wash his clothes and bathe himself in water." He also forbade intercourse with menstruating women and with "unclean" women or women who had a discharge.

No further historical references to prophylaxis is found until the Thirteenth Century, when Guillaume de Salicet attributed the onset of gonorrhea to filth retained under the prepuce after connection with an unclean woman and advised washing with water after every suspicious cohabitation. Prophylaxis was still more strongly advocated by his pupil, Lanfranc, who recommended washing the parts in urine or with equal

parts of vinegar and water. Thus he was the first advocate of chemical prophylaxis.

John of Gaddesden, professor at Oxford in the Thirteenth Century, adhered to Lanfranc's principles of prophylaxis and suggested washings with acidulated water or with urine if no water were available.

The facts concerning the invention and introduction of the condom or protective sheath are shrouded in obscurity and confusion. History indicates that this invention was introduced late in the Seventeenth Century or early in the Eighteenth Century. It was described by Turner in 1717 and its invention attributed to a Dr. Conton, an Englishman who made a protective sheath from the sheep's cecum for covering the penis. People, instead of showing their gratitude, supposedly so ridiculed him that he changed his name to Condom or Cundum, which explains the name. Other historians ascribe the invention to a Frenchman, Monseiur de Condom, who was a friend of de La Rochefoucald. Other authorities seriously question the existence of either a Dr. Conton or a Monseiur de Condom and think it probable that the name is derived from the Latin "condere" or "condus", meaning to hide or to protect. Regardless of who invented this beneficent device which has prevented so much dreaded affliction and so many unwanted human beings, he should be numbered among the great inventors and benefactors of the human race and a fitting monument should be erected to his memory.

The condom is the best-known and most used of all prophylactic and contraceptive devices. It is known by a variety of names, such as "sheath," "safety", "rubber", "Cundum", or "cundrum". It is said that about 1,500,000 are used daily in the United States. It is a thin, elastic covering which fits closely over the penis and is used during intercourse.

Phillippe Ricord, the great venerologist of the early Nineteenth Century, reputedly said that "the condom is ever a cuirass against pleasure and a cobweb against infection"; and this probably was true of the type of condoms used in that day and age. We still find this objection being voiced today and many still insist the use of the condom decreases the pleasure of the sex act. This is more in the mind than an actual fact, but it is well to impress the sexually promiscuous that it would be better to have a number of sex contacts during which protection is afforded than to have one contact and contract a venereal disease and not be able to have further sex contact for a long period of time. The condom may tear and so admit infection, and once in a while some one is seen who alleges he was infected in spite of its protection. But as Keyes says, "the infection in such cases doubtless results from preliminary skirmishing".

The fact remains, however, that next to avoiding sex contacts altogether, the condom offers the greatest protection to both men and women. The condom keeps the surface area of the penis and the vagina from coming in direct contact during the sex act. Thus the germ of gonorrhea or syphilis can not pass from the infected parts of one person to the healthy partner. If the condom is to do an efficient prophylactic job, it must be well made. The condom is obtainable in several types of rubber or latex and in "skin" made from the cecum of sheep. Rubber or latex condoms are cheaper, soft to the touch and easily rolled on. In good qualities they are amply strong and afford excellent protection if of full size and not of the "short" or glans type. The "skin" or "fish skin" condom is more expensive, is more durable, and is extremely thin and soft when moistened. It should be drawn on like a glove and then moistened.

Today condoms bought from reliable sources are very effective in preventing venereal diseases. The condom properly used is 100 per cent effective in preventing gonorrhea, but still leaves the individual liable to syphilitic infection on the uncovered parts of the genitals such as the base of the penis, scrotum, or pubic region.

To obtain adequate protection from the condom, certain techniques or rules for usage are necessary. The condom should not be handled more than necessary; it is delicate and thin and fingernails may easily tear it. It should not be carried in the pocket or crammed into a wallet. It should be kept in its original container until used. The condom should be applied where the individual can see what he is doing and he should not "fumble in the dark". Ready rolled condoms are very easy to put on; unrolled condoms must be rolled by hand before use. The condom should be rolled down on the penis with one hand, holding onto the tip with fingers of the other hand, so as to exclude air from the end. Air must be excluded to lessen the chance of breaking during intercourse. No contact between the vagina and penis should be made before the condom is put on, and if the condom breaks while it is being put on, it should be discarded and a new one applied.

If sex movements are continued after the discharge of male fluid and the man is infected, the woman may become infected, as the sexual movements force the fluid out of the condom and into contact with the woman's genitals. If the penis is left in the vagina until it becomes soft, the condom may slip off and thus render infection possible.

Immediately after intercourse the man should reach for the base of the condom, hold it firmly to the base of the penis and withdraw. The outside of the condom may have infective material on it. Therefore, it should be removed in one

swift motion, turning it inside out as it comes off and should be discarded immediately.

Chemical prophylaxis is used after sexual exposure and is mostly of value to the male. The purpose of the chemical prophylaxis is to kill the germs of gonorrhea or syphilis after they have reached a healthy person's organs. Chemical prophylaxis, to be effective, must be used within one hour after exposure and not later than two hours afterwards. The longer the time elapsed between exposure and use of the prophylactic, the less effective it is, and it is of no value if applied later than 12 hours after exposure. Immediate urination after exposure and thorough washing of the parts with soap and water is of great help and should always be done. The entire genital area should be washed and preferably a thorough bath should be taken. In the woman, chemical prophylaxis can be effectively given only by a doctor, although a thorough cleansing douche with a mild antiseptic is of value.

For the male, prophylactic packages or kits can be bought in drug stores; in the army, kits are issued to the men. The kits usually contain two tubes of chemicals. One tube contains an ointment of silver salts for the prevention of gonorrhea. The other tube contains calomel ointment for protection against syphilis.

Chemical prophylaxis against gonorrhea depends upon the silver salt preparations, either in ointment or in solutions such as argyrol or protragol, which is injected in the urethra and then held there for five minutes. Since 1943, 15 per cent sulfathiazole ointment has been found effective and is being used. In some Army centers, the prophylactic use of sulfathiazole tablets to be taken by mouth have been used after exposure, but this method is not without danger and its effectiveness is questionable.

Chemical prophylaxis against syphilis was discovered by Metchnikoff more than 40 years ago. It consists of the application of 33-1/3 per cent calomel ointment, also called Metchnikoff's ointment in honor of its discoverer. Metchnikoff tried his experiment on a heroic young medical student by the name of Maisonneuve, who allowed himself to be inoculated with syphilis and then treated with calomel ointment. It was successful in preventing infection. To be effective, calomel ointment should be rubbed into the genitals, the scrotum, the thighs, and the hairy parts for a full five minutes.

The Army has long been an advocate and pioneer in venereal prophylaxis. Voluntary prophylaxis was introduced into the Army in 1909, compulsory prophylaxis in 1912. In 1939, compulsory prophylaxis was abolished and greater emphasis placed on education. During World War II all troops throughout the Army were provided not only with condoms for mechanical prophylaxis, but also prophylactic chemical kits, and in 1943, a highly effective one-tube chemical prophylaxis, was developed and distributed. This tube contains an ointment made up of 15 per cent sulfathiazole and 30 per cent calomel. The importance of the role which prophylaxis played in our Army of eight million men in World War II is indicated by Army statistics which reveal that the Army required and issued more than fifty million individual prophylactic items monthly.

In addition to this, the Army provided prophylactic stations located in all Army camps and in cities or towns where soldiers congregate. These prophylactic stations are identified by a "green light" so they are easy for the men to find. They are manned by medically trained men, capable and trained to administer prompt and proper prophylaxis. Statistics clearly show that this enormous prophylactic program was effective in preventing a vast amount of venereal disease.

Surely, in civilian life, the taboos and prudery of the past should be cast aside and prophylaxis and education in the use of prophylactics, as well as every other available weapon should be used to fight and prevent venereal disease.

Management of the Neuropsychiatric Patient

The majority of neuropsychiatric patients seen in general hospitals fall into the class of the psychoneuroses. While it might be desirable for community hospitals to provide a separate wing for the care of psychotic patients, at present their disposition is usually only a matter of diagnosis and transfer to a mental institution. Psychoneurotics, however, make up a fair proportion of patients in a general hospital at any given time, and their number will undoubtedly increase as discharged servicemen filter back into civilian life.

With the advent of electroshock therapy, it has been possible to give more effective treatment to certain classes of these patients, and it is probable that the time will come soon when the use of electroshock will be a standard treatment in all general hospitals. Three classes of patients benefit primarily from electroshock treatment in general hospitals: the middle-aged patient with vague somatic complaints, displaying lack of ability to concentrate and mild depression, whose illness can be reduced from months to weeks; the agitated and depressed younger individual with obsessive ideas; the young woman who, following childbirth, becomes depressed, confused, and unable to care for her child. Electroshock therapy is only an adjunct to psychotherapy, however, and should be given only by trained personnel after psychiatric evaluation.—H. Craig Bell, M.D., Abington, Pa.; Penn. Med. Jr., Vol. 49, No. 3, Dec., 1945.

Meningioma of the Cervical Spinal Dura with Postoperative Uremia and Renal Insufficiency

WILLIAM B. WARTMAN, M. D.

THIS white male, aged 39 years, was admitted to Lakeside Hospital on November 7, 1945, because of headaches and dizziness. He was in good health until 5 months prior to admission at which time he fell off a wagon, struck his head, and was knocked unconscious. He was treated for fractures of his right ribs. Two and one-half weeks before admission he developed dizziness, headaches, and weakness in his hands, arms and legs. He vomited once three weeks prior to admission.

Admission physical examination revealed a temperature of 38.3° C., pulse 90, respirations 20, and blood pressure 120/70. There was weakness of both upper and lower extremities and atrophy of the muscles of hands and legs. Abdominal reflexes were absent. Tendon reflexes were equal and active but there was some loss of vibratory and position sense in the left leg. Examination of the urine on admission showed a specific gravity of 1.030, no albumin or sugar, and 8 to 10 white blood cells per high power field. On admission the hemoglobin was 95 per cent, red blood count 4.5 M., and white blood count 7850. X-ray studies of the spinal canal revealed a block at C-7.

A cervical laminectomy was performed by Dr. Claude Beck on the 6th hospital day and an extradural meningioma 3.5 x 3 x 0.4 cm. was removed at the level of C-3. During the five-hour operation a great amount of blood was lost from a dilated plexus of veins which extended from C-7 to C-3. The patient's blood pressure dropped to 80/50 during the last three hours of operation and stayed at shock levels for 12 hours postoperatively. He received 500 cc. of whole blood during the operation and 500 cc. on his 8th hospital day. During his 10 postoperative days he passed small amounts of urine, showed consistent 3 plus albuminuria, and the blood urea nitrogen rose steadily until on the 10th postoperative day it was 165 mg./100 cc. Although the urine microscopically showed occasional red blood cells it was benzidine negative. On the 8th postoperative day the icterus index was 34. He died on the 10th postoperative day.

The postmortem diagnoses were meningioma of the cervical dura, acute diffuse nephrosis (lower nephron syndrome), and acute necrosis of the liver. There was also hypertrophy and dilatation of the heart, subacute esophagitis with ulceration, ascites (3100 cc.) and icterus.

COMMENT

The meningioma was extraordinary because of its extradural situation in the spinal meninges and the great number of psammoma bodies. It could not be completely removed at operation and it is likely that if the patient had lived it would have recurred. Dr. Beck pointed out that the blockage of spinal fluid at C-7 and the symptoms of cord compression were due to a plexus of veins at C-7. Actually the tumor was at C-2 and C-3 and in his opinion caused no functional disturbances.

The lesion of greatest interest was the acute nephrosis which resulted in renal insufficiency, uremia and death. Although the whole nephron was involved in this case, it was principally a lower nephron lesion and comparable to the kidneys in Bywaters and Dible's[1] cases of compression shock. The question arose as to the cause of the nephrosis. It is possible that it was due to a transfusion reaction, and the microscopic changes in the liver such as dissociation, pigmentation, and necrosis of cord cells, add further support to this theory. However, there was no demonstrable blood incompatibility and the debris in the tubules did not stain for hemoglobin, although this case was probably exceptional because the patient lived longer than does the usual patient suffering from a blood transfusion reaction so that there was the possibility that routine hemoglobin stains (benzidine) could not be relied on completely.

Another possibility which was suggested was that the nephrosis was due to prolonged anoxia and shock. Certainly the patient lost a large quantity of blood and was in shock for a long period of time. Dr. Ewald Selkurt[2] and Dr. Max Miller pointed out that in experimental animals in which the renal artery had been partially clamped producing renal anoxia, or in the presence of hemorrhage shock, the animals died of renal failure. At autopsy there was a mild degree of nephrosis involving principally the proximal convoluted tubules.

SUMMARY

This is the case of a 39 year old white man who was operated upon for an extradural meningioma of the neck. During the operation excessive bleeding occurred from a plexus of veins below the tumor and the patient was in hemorrhagic shock. Anuria and uremia developed and the patient died ten days after operation. Autopsy revealed an acute diffuse nephrosis which was most marked in the lower nephron. The etiology of this nephrosis was obscure. Although a transfusion reaction could not be excluded it seemed unlikely. It was suggested that the cause may have been hemorrhagic shock.

BIBLIOGRAPHY

1. Bywaters, E. G. L., and Dible, J. H.: The Renal Lesion in Traumatic Anuria. J. Path. & Bact., 54:111-120, 1942.
2. Selkurt, E. E.: The Alteration of Kidney Circulation and Function Resulting from Complete Renal Ischemia and Hemorrhagic Shock. Clin. Bull. Sch. Med. Western Reserve Univ. and Assoc. Hosps., 9:87-94, Nov., 1945.

*Selected by H. T. Karsner, M.D., from the Clinico-Pathological Conferences at the Institute of Pathology, Western Reserve University and University Hospitals, as the thirty-first of a series of cases to be published under the heading of "Case Records Presenting Clinical Problems".

Diseases of the Gallbladder and Common Duct: Diagnosis and Management

R. P. RIZZO, M.D.

The Author

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BECAUSE the diagnosis and management of diseases of the gallbladder and common duct are a major problem to every physician and surgeon, and since we have had a heavy run of interesting and varied cases on our surgical service in the past few months, this appears to be an opportune time to briefly discuss gallbladder disease which is by far the commonest cause of upper abdominal trouble.[1]

The literature on cholecystic disease is voluminous and an attempt to cover the whole subject is obviously impossible. I have tried to review the literature in the well-known medical journals of the past few years. A few aspects will be discussed about which some controversy still exists. However, the major part of this paper will be devoted to those phases of the subject about which definite knowledge is available.

INCIDENCE

Eliason and Stevens[2] state that 15 per cent of the people in the United States suffer from biliary disease and that this increases to 30 per cent among people beyond 45 years of age. Crump has reported from postmortem studies that approximately 60 per cent show evidence of cholecystic disease, and Mentzer[3] records 66 per cent in 612 routine postmortem examinations at the Mayo Clinic. Robertson and Dochat[4] in their postmortem figures confirm the clinical experience of most physicians that among women cholecystic disease is likely to develop at an earlier age than among men and also that it is much more frequent in women. Twenty-two and six-tenths per cent of the women and only 12.5 per cent of men had stones. In their analysis they were unable to confirm the common belief that pregnancy is a major factor in the causation of stones. The incidence of gallbladder disease will probably increase in time because of the well-known trend in the age composition of the population toward higher age levels and the fact that the incidence of cholecystic disease increases with each decade of life.

ETIOLOGY

It seems to have been almost immediately assumed that inflammation of the gallbladder is due to an infection. However, many phases of the clinical picture of cholecystitis do not fit in perfectly with such a concept of pathogenesis. For instance, cholecystitis is relatively infrequent in children and increases very definitely with age. One would anticipate that the reverse would be true since bacterial invasion of the portal stream is commoner in younger individuals, being seen in association with acute appendicitis, peritonitis, obstruction, et cetera. Often in acute cholecystitis the badly damaged gallbladder is found to be sterile, as well as to contain bile.

Because of the very frequent association between obstruction of the cystic duct and acute cholecystitis, it is natural to assume that the substance obstructed, namely bile, must play an important part in the production of this inflammation. Womack[5] and associates conducted experiments on dogs to demonstrate the damaging action of bile on the gallbladder wall. If complete obstruction of the cystic duct was produced after the gallbladder had been emptied of its bile and the contents replaced with physiologic saline, there was no evidence subsequently of inflammation of the gallbladder wall. Hydrops ensued. However, when obstruction was performed with bile left imprisoned, the resulting inflammation varied in severity and in type in direct proportion to the content and concentration of the bile obstructed. They conclude that three important factors are involved in the production of cholecystitis: (1) Obstruction of the cystic duct; (2) the action of bile on the gallbladder wall; and (3) the occasional secondary presence of bacterial infection which would be superimposed upon the chemically-damaged tissue.

In 354 consecutive cholecystectomies at Barnes Hospital, 32.8 per cent showed histologic evidence of a lipid or bile reaction deep in the wall of the gallbladder. This concept of the etiology would consider cholesterolosis or "strawberry gallbladder" as an early form of cholecystitis. It would not place it in a category apart. This concept would correlate the association of chole-

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cystitis with precipitation of the components of bile in the gallbladder to form stones and the relationship of these stones to inflammation.

DIAGNOSIS

The clinical manifestations of cholecystic disease are well known. However, one must keep in mind that symptoms are varied and often fail to follow the textbook picture. The fair, fat, flabby, fertile, flatulent female of 40, described by Owens, with pain in the right upper abdomen is typical of this disease. The condition also occurs frequently in patients with other physical characteristics and may produce symptoms suggesting peptic ulcer, coronary disease, diaphragmatic hernia, and appendicitis, to mention only a few. Sanders[6] divides patients according to the predominating clinical symptoms into three groups: (1) Those with pain, usually manifested by recurring bouts of biliary colic; (2) those with digestive disturbances, qualitative food disturbances, belching and flatulence; and (3) those with both biliary colic and digestive disturbances.

The diagnosis of acute cholecystitis is not difficult. In more than 90 per cent of the cases there is a past history of cholecystic disease, often with minor attacks of biliary colic. The attack is characterized by the onset of acute abdominal pain increasing in severity and accompanied by nausea and vomiting. Elevation of the leucocyte count and of the temperature is not remarkable in the early stages. This emphasizes the fact that attacks of acute cholecystitis are primarily obstructive, rather than inflammatory in nature. In most cases infection does not play an important part until after 48 hours and, in about half the cases, cultures of the contents in the first 48 hours are sterile.

Saint[7] states that the development of a palpable gallbladder is the most important clinical manifestation that the pathological process has progressed to a point of impending perforation.

CHOLECYSTOGRAPHY

It is fortunate that in the diagnosis of cholecystic disease a test as simple and reliable as cholecystography is available. Of course, a complete history and physical and good clinical judgment are essential but, in dealing with a condition of which the manifestations are so varied, a test such as cholecystography is invaluable.

Cholecystography had its advent in 1924. Its simplicity depends on the limited number of possible diagnoses. Either the X-ray reveals a gallbladder shadow or there is no shadow. If there is a shadow, either the gallbladder contains stones or it contains no stones. Under average conditions, in any X-ray department doing a considerable amount of diagnostic work the accuracy approaches 99 per cent. Including borderline cases, in which there is a question of opinion whether the gallbladder is diseased enough to interfere seriously with its function, there is absolute accuracy of at least 95 per cent. Sosman[8] at Peter Bent Brigham Hospital reports that approximately 20 per cent of all gall stones are opaque enough to be visible without cholecystography.

Last year a new drug, "priodax", was put on the market and ever since it has almost entirely replaced the use of tetraiodophenolphthalein. There is definitely less toxic reaction, such as nausea, vomiting and diarrhea, and there is usually little, if any, opaque residue in the bowel to obscure the gallbladder area.

The facts that may be demonstrated by cholecystography are the size, shape and position of the gallbladder, the degree of filling, the relative concentration, the presence or absence of shadows indicative of calculi and the amount of emptying as revealed by a decrease in size, usually one hour after a fat containing meal. If there is no visualization of the gallbladder by opaque material, the logical interpretation is a non-functioning gallbladder. If the gallbladder does not respond to the fatty meal, and does not decrease in size, little or no importance can be attributed to this finding. In the great majority of patients, the delay in emptying is physiologic and of no clinical importance. It has been shown that cholesterolosis or "strawberry gallbladder", or even an acute cholecystitis can be compatible with normal function and a normal cholecystographic shadow.

Clagett[9] enumerates the criteria necessary for a diagnosis of cholecystic disease sufficient to warrant operation as follows: (1) A satisfactory history of one or more attacks of biliary colic or its equivalent, with or without fever, chills and jaundice; (2) residual soreness in the region of the gallbladder following episodes of biliary colic; (3) indigestion which is usually characterized by flatulence, bloating and discomfort; (4) a cholecystogram which gives evidence of a non-functioning gallbladder or of the presence of stones; and (5) reasonably exact exclusion of conditions which simulate cholecystitis.

MANAGEMENT

From the therapeutic standpoint diseases of the gallbladder can be divided into three main groups: (1) Chronic noncalculous cholecystitis; (2) chronic cholecystitis with stones; and (3) acute cholecystitis.

CHRONIC CHOLECYSTITIS

It is generally conceded that chronic noncalculous cholecystitis does not warrant operation since it does not fulfill the necessary criteria for such a procedure. These are the patients who do not obtain good results from operation. It

includes those patients who have a vague type of dyspepsia and abdominal discomfort, but who have not had biliary colic and do not have positive cholecystographic evidence of disease. These patients will probably continue to complain under any type of medical management because their complaints are usually on a functional rather than an organic basis. Poor results attributable to ill-advised surgical procedures in such cases should not be allowed to discredit the good results following operation performed under proper indications.

Alvarez[10] in a recent article makes a plea for thoughtfulness and specialization in the treatment of cholecystitis and a protest against the unthinking treatment of all cases with the same diet and the same mixture of bile acids with a laxative.

Throughout the United States today the current medical treatment for cholecystitis is a diet low in fat and a prescription for some proprietary pill usually containing bile salts with some cheap laxative. How logical and scientific is this treatment? Why should a patient with a diseased gallbladder avoid fat? Originally the idea probably was that bile helps in the digestion of fats, and that, hence, when there is a disease of the biliary tract, fats should be avoided. Actually, in all cases without jaundice, the bile is flowing from liver into duodenum without hindrance. If patients with cholecystitis frequently suffered from an imperfect digestion of fats, one would often expect them to have diarrhea with fatty stools and a progressive loss of weight, but this is not the case. Most of them suffer from constipation and many digest so well that they gain in weight.

Dr. Alvarez's impression, from talking to scores of persons who have been on a low fat diet, is that it did not make much difference in their digestive comfort. They will tell you that the secret of avoiding trouble was never to eat a **big** meal consisting of rich foods of any kind. Some learn that certain foods like onions, cabbage, or raw apples tend to cause trouble, and they obtain some relief by leaving these foods alone.

No one seems to have thought that the patient who has a non-functioning gallbladder removed surgically is no different physiologically than he was before the operation, and yet afterwards he is generally told to eat what he pleases and he digests everything he eats.

Another reason given for the avoidance of fats is that with a low intake of cholesterin the formation of gall stones may be avoided. There is no evidence in the literature that this precaution is worth taking, but granting that it is in some cases, it can not be worth taking in the majority of cases in which the gallbladder is so packed with stones that it would be impossible to get any more in. A diet sufficiently low in fats and carbohydrates can, of course, help by reducing the weight of the patient if she or he is stout, but there is no reason for expecting this to restore a badly diseased gallbladder to a healthy state. To avoid fats in the diet is to invite stagnation of bile in the gallbladder.

The pill containing bile acids is probably given with the idea that these substances will cause the bile to flow faster flushing out the gallbladder and with the flushing there will be a clearing away of infection and perhaps some small stones. Phibbs[11] and associates showed that there is no great increase in the flow out of the gallbladder when they gave "ketochal", a mixture of bile acids, to dogs.

It would be better if all physicians would oftener admit that there is no logical medical or dietary treatment for cholecystitis, especially when the bile has ceased to flow easily into and out of the gallbladder, or when the organ is full of stones, or its wall is stiffened with scar tissue and full of bacteria.

STONES

Chronic cholecystitis with stones constitutes a definite indication for surgical treatment. Although the literature is filled with arguments, pro and con, concerning the dangers associated with the presence of gall stones, most authors are convinced that innocent gall stones do not exist and that they should be removed. The physician who tells a patient not to bother the gall stones until they bother him is assuming undue responsibility. The risk of cholecystectomy performed on a patient in good general condition is a fraction of 1 per cent.

Clute and Kenney[12] of Boston report a mortality of 0.5 per cent in 201 cases of cholecystectomy for chronic cholecystitis, 7 per cent in 71 cases of acute cholecystitis and 9.5 per cent in 84 cases of stones in the common duct. They present evidence that there is far too great a delay in the surgical removal of gall stones. Delay in acute cholecystitis means waiting for infection and for the possibility of perforation of the gallbladder which occurs in about 20 per cent of the cases. Cawley and Harkins[13] report perforations in 13 per cent of 2,266 cases of acute cholecystitis.

An early elective cholecystectomy is wiser than an operation into which one is forced by complications of the disease. Strictures of the common duct, duodenal injuries and fistulas, overlooked cystic and common duct stones—these are only some of the penalties exacted by ill-advised attempts at surgery of the biliary tract. It is most important that the surgeon who elects to operate on biliary tract disease shall be well trained and experienced in the technique

of the procedure. The dangers of gall stones lie, first, in the complications they may produce and, secondly, in the surgery required for their removal. These dangers can be avoided, to a large degree, by the performance of the operation before complications occur and by a better quality of surgery.

In a follow-up of a series of 150 patients with cholecystic disease, who refused surgical treatment and who had a non-functioning gallbladder, X-rays at the Mayo Clinic revealed that within two years after the diagnosis had been made, 27 per cent of the patients had been operated upon for serious complications of cholecystic disease such as jaundice, pancreatitis and perforated gallbladder.

ACUTE DISEASE

Acute cholecystic disease comprises about 20 per cent of all diseases of the biliary tract encountered in medical and surgical practice. "Acute obstructive cholecystitis" is more descriptive of the pathological condition present. Acute obstruction, with or without infection, leads to increased intravesicular tension. Colicky pain results from the efforts of the gallbladder to empty itself. The increased intravesicular tension results in interference with blood supply and the development of gangrene, usually beginning in the fundus since it is farthest from the source of blood supply. Gangrene results in perforation.

Clute, Kenney[14], Clagett[15] and many others advocate surgery within 48 hours of the attack of acute cholecystitis provided facilities are available and the patient's condition will permit operation. This results in a saving of time and money for the patient and, more important, it prevents suffering and minimizes the risk.

If operation is performed early, usually it is not difficult or hazardous. The tissues are edematous but have not yet become indurated and friable. The risk of peritonitis is negligible. The edema in the tissues may control bleeding, and usually results in an excellent line of cleavage for the dissection. The retrograde method from fundus down is often valuable in these cases. If cholecystectomy can not be performed accurately and safely because of difficulties in obtaining adequate exposure, there should be no hesitation about performing a cholecystostomy instead.

Now we shall briefly discuss the common and hepatic ducts since they are so closely associated with gallbladder disease.

COMMON DUCT

Cole, Ireneus, and Reynolds[16] report a series of 23 consecutive cases of stricture or absence of the common duct. Forty-eight per cent were so definitely related to the original operation of cholecystectomy that trauma appears to have been the direct cause of the stricture. In another 28 per cent relationship of the stricture to operation was probable, thus suggesting that 76 per cent were related to the operation. This is slightly less than the figure of 80 per cent given by Cattell[17] and of 90 per cent given by Walters.[18]

The causes of benign stricture of the common bile duct are:

1. Operative trauma:
   (a) excision, ligation or incision,
   (b) clamped while controlling hemorrhage,
   (c) cystic duct ligation too close,
   (d) during gastrectomy,
   (e) following choledochostomy.
2. Ulceration due to gall stones.
3. Inflammation:
   (a) related to cholangitis.
   (b) abscess around duct,
   (c) pyelophlebitis.
4. Secondary to pancreatitis.
5. Tumors and cysts.

The chief conditions for which operations on the ducts are performed are: (1) stones, (2) carcinoma, (3) stricture, and (4) pancreatic lesions.

Sanders[19] reports 596 cases of operations on the biliary tree with a 3.4 per cent mortality following operations without exploration of the ducts and a 10 per cent mortality following cholecystectomy or cholecystostomy with choledochotomy. Thus, the mortality rate was three times higher.

Cattell[20] of the Lahey Clinic Group reports that the common duct was explored in 48.8 per cent of the cases. However, stones were found in only 29 per cent of the explored group. Thus, Sanders[21] does not see the advisability of subjecting patients to choledochostomy, even though the risk is small, without clear indications.

In the absence of jaundice and a palpable stone in the duct, his[21] criteria for opening the dilated ducts are: The discovery of a contracted gallbladder; small stones in the gallbladder with an enlarged patent cystic duct; the presence of flocculent bile in the ducts as determined by aspiration; and a history of chills and fever. Not infrequently, the common duct is abnormally dilated, incident to occlusion of the cystic duct with a stone, in long standing gallbladder disease, the duct having taken over the function of the gall bladder. If the bile is clear, there is no point in choledochostomy.

In recent years Sanders and associates have made a practice, when possible, of dilating the lower end of the duct to almost normal size with Bokes dilators. No. untoward postoperative effects have been encountered. Combined with thorough exploration of the ducts, lavage, and the T-tube and medicinal measures to stimulate bile drainage, this procedure has been ample to insure the patient against further trouble. They

do not consider it necessary to make cholangiograms at the time of operation, though they do so before withdrawing the T-tube when indicated.

Experience has shown that the gallbladder should be removed before choledochotomy in order to prevent small stones from passing through the cystic duct into the common duct. This procedure insures one that the common duct is entirely free of stones at the conclusion of the operation. Also, the incision in the common duct should be made in the longitudinal direction. Particular care must be taken lest the duct be torn transversely, since then the stage is set for the development of a stricture unless an extremely careful repair is made.[22]

Thus, choledochotomy is definitely indicated when a stone is palpable, the patient is jaundiced, or has a history of jaundice, or chills and fever, and the common duct is abnormally enlarged and thickened; when there are stones in the gallbladder and the cystic duct is dilated; or when flocculent bile is present in the duct, pointing to a possible impalpable stone in the ampulla. Mere dilatation of the common duct is, in itself, not an indication. In many cases, the dilatation is physiologic; in others, it is due to extrinsic mechanical obstructiin; and in still others it is secondary to gallbladder infection and is amenable by cholecystectomy alone.

PREVENTION OF STRICTURES

In an editorial Lahey[23] states that many common and hepatic duct strictures can be avoided by the application of a few reliably simple measures—better relaxation which can be provided by properly given and supervised spinal anesthesia; longer incisions which permit easier and wider exposure; rotation of the hepatic flexure, duodenum and pylorus to the left with gauze pads and retractors; good light focused in the deep hole in which the structures lie; the individual demonstration and ligation of the cystic artery before the gallbladder is removed, and, finally, by the clear demonstration of the relationship between the cystic, common and hepatic ducts before the cystic duct is clamped and cut.

If these steps are carried out, there will be fewer of these unfortunate calamities than there are now. Reconstructive operations upon the bile ducts should not be undertaken without assessing one's ability to meet the technical difficulties occurring with them and without realizing that failure of the first reconstructive operation can make the following operations more difficult and, at times, one in which it is impossible to obtain a satisfactory result.

CARCINOMA

In the past few months on our surgery service, we have had three cases of biliary tract carcinoma. This represents a relatively high incidence. Three-tenths per cent of Sanders' series had carcinoma of the common duct and 0.8 per cent of 33,500 operations on the biliary tract at Mayo's had carcinoma of the gallbladder.

Involvement of the extra-hepatic biliary tract by carcinoma is one of the most hopeless situations confronting the surgeon. Brunschung and Bigelow[24] report seven cases in which radical resections of various types were done for carcinoma. Six died soon after surgery and one lived almost one year. There is apparently no direct association of duct stones to carcinoma of the ducts such as is observed between gall stones and carcinoma of the gallbladder.[25]

ROUTINE TREATMENT

Before presenting a series of nine cases each illustrating a different aspect of gallbladder disease, I shall say a few words about our routine pre- and postoperative orders at St. John's Hospital.

Besides routine counts and urine, blood is drawn for typing in those cases which are considered fair or poor risks. Our blood bank has facilitated the giving of transfusions so that blood is always available. A full liquid diet is given the night before surgery and a Levine tube is inserted with Wangensteen drainage. This is left in place when the patient is taken to surgery. Intravenous glucose and vitamin K are given on the day prior to surgery. Prostigmin is given hora somnis with vitamin K and both given in the morning of surgery. Preoperative medication is morphine sulfate and scopolamine which give good results with spinal anesthesia. One hundred fifty to 200 milligrams of novocaine are used for spinal anesthesia. This is given in the second lumber interspace and is supplemented with sodium pentothal only when needed for the apprehensive patient.

Postoperative orders include intravenous fluids, blood, aminoacids, vitamin K, ascorbic acid, prostigmin, Wangensteen drainage and penicillin if needed.

CASE REPORTS

Case 1. Twenty-nine year old white female admitted complaining of pain in the right upper quadrant radiating to the back with nausea and vomiting and mild jaundice. The pain began following a pregnancy in September, 1944. Blood work was normal except for a 23 mm./hour sedimentation rate and an icteric index of 55. The stool was positive for bile. X-ray revealed no structure to suggest gallbladder and no shadows diagnostic of stone with a diagnosis of pathological gallbladder. She was taken to surgery on October 31, 1945, and a large distended gallbladder with stones was found. The cystic duct was slightly dilated. The common duct was aspirated and flocculent bile obtained. The common duct was opened and explored. No stones were found and a large probe was admitted into the duodenum. A T-tube was placed in the common duct. The head of the pancreas was swollen.

The patient had a relatively uneventful course except that no bile was grossly evident in the stool. So on the 10th postoperative day a cholangiogram revealed only a few drops of dye in the intestinal tract. The common and hepatic ducts were not distended. However, the distal end of the common duct was irregular and showed a radiant area suggestive but not diagnostic of stone. Her stools became normal and she had no complaints. A repeat cholangiogram on her 20th postoperative day showed a marked change with the oil readily entering the intestinal tract with no evidence of obstruction. Her icteric index was 4. She was discharged on her 21st postoperative day with the T-tube in place. This was removed with no ill effects on her 30th postoperative day. The obstruction which she had for a short while after surgery was evidently compression of the common duct by the swollen pancreas. However, a small stone may have been present and it may have passed spontaneously.

Case 2. Seventy-three year old Italian woman admitted complaining of sharp pains in the right upper quadrant. She had had similar severe attacks for a number of years, having been hospitalized a number of times but always refusing surgical intervention. She had a wbc of 10,500, icteric index of 10, and a temperature which spiked between 101° and 99° daily. She was taken to surgery on November 2, 1945, with a preoperative diagnosis of chronic cholecystitis with choledocholithiasis and cholecystolithiasis. The gallbladder was thickened and contained stones. The common duct was markedly distended about one inch in diameter. A large stone was removed from the common duct and a T-tube inserted. Her postoperative course was uneventful with her temperature down to normal on the third day. Cholangiograms on her 9th postoperative day revealed a normal common duct with dye in the intestine and no shadows diagnostic of stone. On her 14th postoperative day the T-tube was removed. She was discharged on her 15th postoperative day in very good condition. This case illustrates that old age is not always a contra-indication to surgery if the patient is prepared properly.

Case 3. Sixty-four year old white female admitted complaining of severe jaundice and abdominal pain with nausea and vomiting. Her attacks began in August, 1944, with a 60 lb. weight loss since then. She had clay-colored stools. Her abdomen was moderately distended with free fluid. There was tenderness in the epigastrium and left upper quadrant. On admission her temperature was 101.3, wbc 7,850, rbc 3.7 million and icteric index 70. Her temperature spiked daily between 102° and 99°. She was taken to surgery on November 23, 1945, and about two or three liters of straw-colored fluid found, a small contracted gallbladder with stones and a large dilated common duct illustrating Courvoisier's Law. The liver was markedly cirrhotic with rounded edges. The duct was opened and two large stones removed. A T-tube was inserted. Her postoperative course was uneventful except for a mild bronchitis. Whether the cirrhosis was coincidental and primary, or rather secondary to calculous biliary obstruction is not known. However, this was most likely a true biliary cirrhosis.

Case 4. Sixty-two year old white female admitted with the diagnosis of an acute appendix. She complained of pain in the right side with nausea and vomiting which began 36 hours prior to admission. There was no history of jaundice, clay-colored stools or intolerance to fatty foods. Her temperature was 101°; pulse, 120, very irregular in force and rhythm; wbc 18,200. She was taken to surgery immediately. The appendix was not acutely inflamed. The gallbladder was markedly distended and tense. White bile was aspirated and it was removed by the retrograde method. Stones were present. This was considered to be an early beginning empyema. The patient was given cedilanid postoperatively. Her temperature was normal on her 5th day. Her hospital course was uneventful except for the auricular fibrillation which was controlled with cedilanid. This case illustrates the advisability of operating acute cholecystitis of less than 48 hours duration.

Case 5. Seventy year old white female admitted complaining of pain in the abdomen which began two weeks previously and which had persisted as a dull ache with a number of sharp attacks of colic in the right upper quadrant. Nausea was present but no vomiting. Temperature was 101°, pulse 84, and blood pressure 160/80. There was a slight icteric tint with marked epigastric and right upper quadrant tenderness with muscle guard. The diagnosis was chronic cholecystitis with stones with an acute exacerbation and the possibility of an early empyema. Wbc was 13,400, icteric index was 7. She was put on penicillin and built up for surgery with whole blood, fluids and vitamin K. On her 6th hospital day with her temperature and counts normal she was taken to surgery. The gallbladder was distended and contained small stones. The cystic artery was in an anomalous position lying right on the common duct which was small and not distended. The artery bled profusely. However,. bleeding was controlled but, in order to make sure the common duct had not been tied in the process, it was opened and found to be patent. A T-tube was inserted. Her temperature was normal on her 3rd postoperative day. She had an uneventful course. The T-tube was removed on the 22nd day and she was discharged on her 25th postoperative day in good condition.

Case 6. Sixty-three year old white male admitted complaining of abdominal pain and fever. He had a cholecystectomy done in 1944 and a large number of stones were found. T-tube drainage was used and prior to its removal, cholangiograms were found to be normal. Since then he has had several bouts of right upper quadrant pain. The present attack began 10 days prior to admission with jaundice which has increased in severity. He has had chills, nausea and vomiting. His temperature on admission was 105.4, pulse 124, and blood pressure 70/30. He was markedly dehydrated, severely jaundiced and in a semi-comatous, delirious condition. An X-ray of the chest was negative. Wbc 14,200, rbc 3.1 million, and sedimentation rate 30 mm./hour. Icteric index 60 and urea nitrogen 90 mg. He was treated with penicillin, blood and intravenous fluids. On his second hospital day his temperature was normal. However, on the 3rd day it began to rise and reached 104.3 on the 8th day. He expired on his 9th hospital day. The autopsy report revealed an old healed cholecystectomy, lithiasis of the intrahepatic and extrahepatic bile ducts, ascending suppurative cholangitis with multiple abscesses.

Case 7. Fifty-four year old white female admitted complaining of right lower guadrant pain and right costo-vertebral pain. Genito-urinary complaints of urgency, frequency and

nocturia x3 were noted. Her temperature was 99.2, pulse 80, wbc 6,750, rbc 4.5 million, and a sedimentation rate of 17 mm./hour. The urine was normal. Intravenous pyelogram and cystoscopic revealed no abnormalities. Gallbladder X-rays revealed an absence of filling suggesting a pathological gallbladder. Upper G. I. series revealed some gastric retention. She was taken to surgery and a large distended gallbladder with stones was found. There was a new growth in the lower mid-portion of the fundus and neoplastic tissue around the common duct. There were metastatic nodules in the liver. The stones were removed and a cholecytogastrostomy performed. She is now on her 18th postoperative day and doing well with temperature normal. Her prognosis is, of course, very poor.

Case 8. Forty-eight year old female admitted with severe right subcostal pain. Wbc 6,800, temperature 101.2, pulse 100, and icteric index 8. A diagnosis of acute cholecystitis with stones was made and she was put on penicillin. She was taken to surgery on her 5th hospital day with normal temperature. There were metastatic nodes in the liver and a malignancy of the fundus of the gallbladder. There was also an empyema of the gallbladder, so it was removed to prevent perforation. She had an uneventful recovery and was discharged on her 16th postoperative day. She expired a few months after her discharge. The pathological report was adenocarcinoma of the gallbladder with empyema.

Case 9. Fifty-six year old female admitted with deep jaundice which had begun approximately six weeks prior to admission. A flat plate revealed a large gall stone. X-ray of the stomach revealed no evidence of any pancreatic tumor, but there appeared to be a herniation of the gastric mucosa into the base of the duodenal bulb. Colon X-rays were negative. Her icteric index was 150. Paracentesis fluid was negative for tumor cells. She was taken to surgery. There was a large amount of straw-colored fluid. The gallbladder was not enlarged. The lower half of the fundus, the common and hepatic ducts, and the head of the pancreas were involved in a carcinomatous process. There were metastatic nodes in the liver. Biopsy confirmed the diagnosis. The patient expired on her 13th postoperative day. The autopsy report showed cholelithiasis, medullary carcinoma of the neck of the gallbladder with extension into the cystic, hepatic and common ducts and metastases to the liver.

BIBLIOGRAPHY

1. Rehfuss, M. E., and Nelson, G. M.: The Medical Treatment of Gallbladder Disease. W. B. Saunders Co., Philadelphia and London, 1935.

2. Eliason, E. L., and Stevens, L. W.: Acute Cholecystitis. Surg., Gynec. & Obst., 78:98-103, Jan., 1944.

3. Mentzer, S. H.: Surg., Gynec. & Obst., 42:782, 1926.

4. Robertson, H. E., and Dochat, G. R.: Pregnancy and Gall Stones; Collective Review. Internat. Abstr. Surg., 78:193-204, Mar., 1944.

5. Womack, N. A.: Origin of Cholecystitis. Surg., Gynec. & Obst., 79:441, Oct., 1944.

6. Sanders, R. L.: The Problems of the Gallbladder. Factors in Surgical Results. Prior's Surg. Abstr., 37:110-114, Feb., 1944.

7. Saint, J. H.: Acute Obstructive Cholecystitis. Surg., Gynec. & Obst., 77:250-260, Sept., 1943.

8. Sosman, M. C.: Radiologic Aspects of Gallbladder Disease. New Eng. Jr. of Med., 231:786, Dec., 1944.

9. Clagett, O. T.: Diseases of the Gallbladder: Diagnosis and Treatment. Surg. Cl. N.A., 25:929-938, Aug., 1945.

10. Alvarez, W. C.: A Plea for Thought Taking in the Medical Treatment of Cholecystitis. New Eng. Jr. of Med., 231:781, Dec., 1944.

11. Phibbs, B. P., Wigodsky, H. S., and Ivy, A. C.: Effect of Oxidized Bile Salts on Gallbladder Bile. Proc. Soc. Exper. Biol. and Med., 45:313, 1940.

12. Clute, H. M., and Kenny, F. R.: The Surgical Aspects of Gallstones. The New Eng. Jr. of Med., 231: 783, 785., Dec., 1944.

13. Cawley, L. L., and Harkins, H. N.: Perforation of the Gallbladder. Surg., Gynec. and Obst., 77:661-668, Dec., 1943.

14. Clute, H. M., and Kenney, F. R.: See Reference No. 12.

15. Clagett, O. T.: See Reference No. 9.

16. Cole, W. H., Ireneus, Call, and Reynolds, J. T.: Use of Vitallium Tubes in Strictures and Absence of the Common Bile Duct. Annals of Surg., 122:490, Oct., 1945.

17. Cattell, R. B.: Benign Strictures of the Bile Ducts. Surg. Cl. N. A., 23:701, 1943.

18. Walters, Waltman: Strictures and Injuries of the Bile Ducts. J.A.M.A., 113, 209, 1939.

19. Sanders, R. L.: Surgical Indications in Diseases of the Common Bile Duct. Annals of Surg., 119:384, Mar., 1944.

20. Cattell, R. P.: Biliary Tract Surgery. Surg. Cl. N.A., 23, 644, 1943.

21. Sanders, R. L.: See Reference No. 19.

22. Cole, W. H., Ireneus, Carl, and Reynolds, J. T.: See Reference No. 16.

23. Lahey, Frank H.: Strictures of the Common and Hepatic Bile Ducts. Surg., Gynec. & Obst., 80:555, May, 1945.

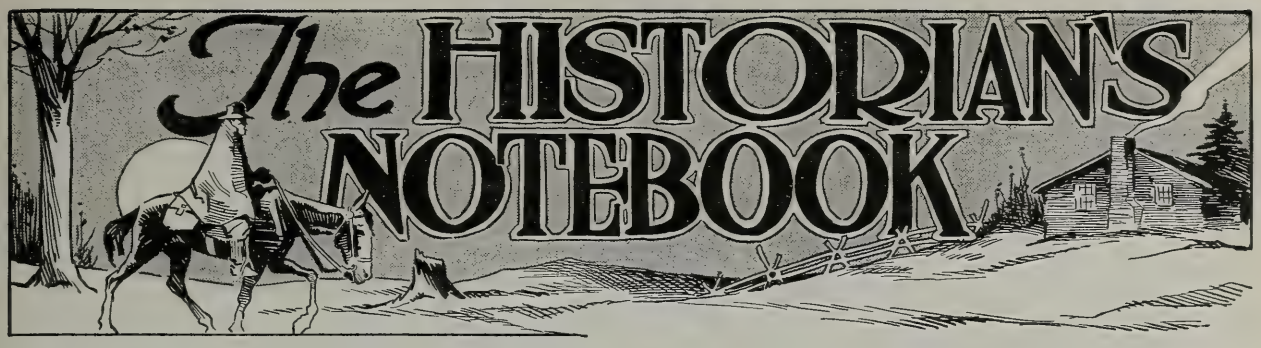
24. Brunschwig, A., and Bigelow, R. R.: Advanced Carcinoma of the Extra Hepatic Bile Ducts. Annals of Sur., 122:522, Oct., 1945.

25. Sanders, R. L.: See Reference No. 19.

Adrenals

The most important chronic disorder of the adrenal glands is Addison's disease. Fifty per cent of patients with recognized Addison's disease have the affliction as a result of tuberculosis. Thompson further states that patients with Addison's disease are particularly prone to develop upper respiratory infections, which indirectly might suggest a further relationship between the adrenal glands and the lungs.

Pottenger and Pottenger reported a study of the effect produced by cortical extract given to guinea pigs inoculated with tubercle bacilli. They compared the results to controls inoculated with tubercle bacilli but not treated, and other controls inoculated but treated with insulin. They reported that 12 of 43 guinea pigs so treated with adrenal cortical extract for periods varying from ten days to the lieftime of the animal showed at necropsy no evidence of tuberculous infection. In the remaining treated animals the infection developed but it differed from the untreated in that it was milder and less extensive. Those inoculated but not treated with adrenal hormone all became infected. This tends to show that the adrenals have some relationship to tuberculosis in the laboratory animal. It is surprising that such an interesting study was not followed by further like experiments.—Peter F. Harrington, M.D., Providence; R. I. Med. Jr., Vol. XXVII, No. 12, Dec., 1945.



Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio

The Vaulting Imagination of John L. Riddell*

ADOLPH E. WALLER, PH.D.

(*Continued from the February issue*)

ITINERANT LECTURER

In 1830, J. L. Riddell launched on a career of his own as an itinerant lecturer on "Chemistry, etc." At this he barely made a living. His good looks, wit, charm, ready expression, ability to demonstrate chemical experiments, may have made up in large measure for any lack of knowledge. He was sufficiently impressed by a lecture "written by Waterhouse in 1811" on the concentric arrangement of the parts of a tree trunk to make note of it. This may have been used in his own lectures. He was at this time groping for a way of life. An entry dated Ogdensburg, N. Y., August 12, 1830, expresses his situation and his hopes:

I propose this fall after completing the present quarter to adopt one of the following courses:— (1) to devote my whole time to the High School in this place for $600 a year, (2) to remain here merely as a lecturer at the same time pursue the study of medicine under Dr. Shuman—Salary $(?), (3) to make arrangements with the patrons for the apparatus belonging to the school and become an itinerant lecturer, (4) totally disconnect myself with the High School, and find some advantageous place either in Canada or United States and establish a school of my own, (5) get a set of medical textbooks and return to my fathers and pursue the study of medicine, (6) I propose to get the loan of the apparatus belonging to the school and give a course publick [*sic*] lectures. If I give the lectures in this place, Ogdensburgh, pay for the use of the apparatus by allowing some of the High School scholars to attend.

All of this seems to indicate the varying and unstrung state of his mind the result probably of the shoestring existence he led. The first item offers the only secure living and he might even have sent home some money, a desire he expresses in other entries in the Journal. The fifth is clearly impossible since he has no money and cannot add to the family burdens at home. It stands on the page in such a position to suggest it is the last possible thing he can think of to do for he adds, "If health permits and nothing interferes I think I shall adopt one of these courses." He is thus beginning to converse with himself in his diary and the next several volumes contain both the repository, *i.e.*, the lectures or scientific notations and the experiments that occur to him and the purely subjective items, his lust-tempting longings, his poetry, his loneliness, his original scientific reflections, his assurance in his own unbounded good health and appetites. It is an *omnium gatherum* full of zests and confused emotions. It can best be described, perhaps, by Bernard Shaw's famous quip, "Youth is such a wonderful thing it is a pity to waste it on the young." At least that is true for the early part of it.

The Author

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VISIT TO CANADA

He has just read Cervantes and is at one Don Quixote. He is pained to note in his diary that he has not recorded any of his "quixotic adven-

tures" for the whole space of days from Monday to Thursday. In other words, he is bored except when he can be at the center of things. Since that occurs only in his imagination he gives it full play. He reminisces over his boyhood, his talks with his companions, one particularly Randolph Williams with whom he plays and who is always on the same side with him in his fights. He is lame and so the fights consist of skillful stone throwing. It is with this boy that he discovers newly acquired passions and an endless fund of conversation. They hike for the sake of these talks. He reads Byron, and Ossian impresses him, and he reads Shakespeare. He fancies himself Don Juan, however, without any apparent consciousness that others may also have built similar imaginings. He travels to Kingston and Brookville in "Upper Canada."

On the hotel "name book" at Kingston he sees the autograph of Le Conte and spends several days shyly waiting to introduce himself. It is the Le Conte who in 1810 prepared and published a *Catalogue of the Plants on the Island of New York*, a friend of Dr. Torrey, whose name became known to Riddell, doubtless, through Amos Eaton. Le Conte, when he finally meets him, tells Riddell that the only plant of the region hitherto unknown to him that he has seen is a species of *Phaseolus*, a member of the bean family. Riddell records that "Le Conte appears to be a stiff churchman as he reads loud."

HISTRIONIC ATTITUDINATION

At one point while still in Ogdensburg, he inscribes, "This day recommended the study of medicine," but when he first began or how he continues is left unrecorded until after he reaches Worthington. He tries hard to develop an eccentric manner, an air of "*hauteur*," and probably dazzles and bewilders such audiences as he is able to collect by the use of a strange high-powered vocabulary. It is here that the reader of the Journal begins to note certain attitudes or strivings in his personal records. He has become an actor. Every notation is for effect. He is thinking of someone standing behind and peering over his shoulder as he writes. On no other grounds can one account for the following entry: "In consigning more of my papers to destruction I found various scraps and documents which I wish to preserve and shall insert them here, not considering them a part of my journal." If he saved the best, that destroyed was of trifling value.

In the spring of 1832, he is at Pittsburgh lecturing on chemistry. No notations explain how he arrived there, but he lectures before a young ladies boarding school. Perhaps the most important acquaintance he makes is with Dr. Robert Peter, who is a friend of Dr. Samuel Hildreth. It is possible that Peter urged Riddell to visit Marietta and to meet Dr. Hildreth. After two years, with some undescribed gaps, the life of an itinerant lecturer may have begun to pall, but not his interest in the young ladies for he records them all by name. He is still without a medical degree and he sees the need of the degree more plainly than the means of obtaining one. A new name to be encountered more often later is introduced at this time. "I yesterday received a letter from my friend Dr. Bennet on the subject of medical colleges." How long he had known Bennet or where he had first met him is an unsolved problem. He leaves Pittsburgh on the steamboat *Nile*, and selects a boarding house in Wheeling on May 1.

JOHN COOK BENNET TRIES TO BARGAIN

In Wheeling, Dr. Bennet promises him a professorship at Western Reserve. He also meets Dr. T. Townsend. He delivers several lectures but much of his time is engaged in romantic longings and he goes so far as to record turning the key on the chambermaid who comes to straighten his room in the boarding house. Her companion maid noting her absence gives an alarm and Riddell is obliged to leave the boarding house. His departure causes him some trouble and the story of its cause is enlarged to his discredit and even reaches the ears of Dr. Hildreth in Marietta.

It is with an almost audible sigh of repose that the June 25, 1832, entry at Marietta reads: "My journal has not been neglected for want of incidents, but rather there have been too many novel occurrences which have engaged my attention." Life at Marietta brings a little of the sense of decorum that is New England back to the straying young John Leonard Riddell. He boards at Mrs. Robins for $1.50 per week. This includes candles. Nothing short of awe is contained in the remark, "and I suppose she does washing." He adds, "we live upon the Holy Scriptures, family prayers and very plain food. Her son is a graduate of the college of Athens." Here in Marietta is a family living much more at peace within themselves than he in his rovings had ever been. He admires it, with limitations, for he finds

a Mr. Hall a pious young man of a high forehead and black hair, a Mr. Archbold, pious also. I should not be popular among them if I remain, because they cannot sympathize with my unregenerated state. I become more and more of a hypocrite the longer I live, when several years younger I spurned the idea of redeeming mankind so I hide my real sentiments by silence.

MEETS THE MOST PROMINENT CITIZEN OF MARIETTA

When he first meets Dr. Hildreth is not recorded, but he writes: "I have been collecting shells in this vicinity and Dr. Hildreth is so

kind to name them. I must insert a catalogue of them." He then lists the names of the shells, but makes no further remarks about Hildreth[6] who is the dean of the physicians of the Ohio Valley at this time after a quarter century of practice in Marietta. He is evidently impressed with the energetic young Riddell and calls on him. Hildreth has been given credit for the longest continuous weather records of the period and for his interest in geology, in botany and in the Mound Builders. Young Riddell takes advice from him on two scores. He collects plants and advertises them for sale and he begins to write about them in the paper. For example, the following advertisement appeared in the Marietta *Friend*, July 12, 1832.

WILD PLANTS

I would respectfully give notice to those who may feel interested that I shall be engaged the remaining part of the summer in making botanical investigations in this county. Specimens of all the native plants, flowers and forst trees will be collected and preserved so that physicians and others wishing for a suite as a reference to the spontaneous productions growing in this region of the country can possess the same by paying one of the following prices:—$4.50 for 100 different species, $1.00 being allowed for paper and $3.50 for specimens including the trouble of collecting, preserving, labelling and arranging, $6.50 for 150 species, $8.75 for 200 species, $10.75 for 250 species.

J. L. Riddell, A.B.R.S.

On July 6 there was an article in the Marietta *Republican* on "The Spontaneous Vegetable Productions of Washington County." This pompous title sounds like a favorite of Dr. Hildreth. The article contained in addition to some of the names of plants an announcement of prices and it is signed by Riddell, as above.

Dr. Hildreth also offered the eminently practical suggestion that Riddell spent the winter in Cincinnati, study medicine and lecture on chemistry and botany in one of the colleges. After his stay in Worthington, that is exactly what Riddell did. He was not, however, able to go to Cincinnati immediately, probably because of the Wheeling escapade. The Journal tells it all:

I wish to get employment as a naturalist. Must write to Rafinesque, to Le Conte and to U. U. Eaton,[7] also to Poulson. Jane the daughter of Mrs. Robins is an innocent good girl. She is 17 or so, eyes as bright and expressive as one could wish. Dr. Hildreth called on me this morning. I have written by Brooks to Rev. Mr. Wheat and to Dr. Townsend informing of the effect of Swearengen's report. Brooks disgusts me. He pretends to be my friend but I have little doubt that he has the means of injuring me here. He is so pious, so elect and all that: so conceited too but he is very destitute of the rules of politeness and ignorant of genteel society. Now he supposes I have been unfortunate, he attempts to give me his friendship as a favor, but I have tried to instruct him lately that I did not wish to receive it as much.

MARIETTA OFFERS NO PERMANENT HOME

In August, he wrote to President Thomas Vaughn Morrow of the Ohio Reformed Medical College at Worthington. He also heard from Dr. Hildreth that Robert Peter had been invited to deliver a course of lectures on chemistry at Lexington. "I do not envy Peter, but I regret that fortune does not favor me." Dr. Hildreth stopped in Wheeling to investigate the Ohio Valley coals[8] and possibly with the express purpose of finding out just what happened to Riddell while he was there. This is the occasion of the following humanly understandable entry: "Old Hildreth is in town from Wheeling overflowing with his sublime discoveries. He lectures or rather bores everyone." It would be interesting to know if Riddell ever found out how Hildreth's paper on the coal deposits of the Ohio Valley had been received in England.

If Dr. Hildreth tried to get Riddell an opening in Cincinnati he was not successful. Riddell received an answer from Dr. T. V. Morrow that stated he "might probably lecture there" and on the strength of that he prepared to go to Worthington. Dr. Hildreth's attitude remained, apparently, one of caution toward an impetuous, attractive young male. The entry in the Journal: "I am considerably intimate at Dr. Hildreth's office with the Doctor and his two sons. They have not introduced me to the female part of the family, perhaps the report from Wheeling has prevented them. Mrs. Hildreth however introduced herself today and showed me a crape-myrtle in her garden." Had Riddell not been so laden with his own blunders, he might have enjoyed reflecting that Rhoda Cook Hildreth was descended from New England sea captains and that crape-myrtle is a native of India. He might have speculated that such a tropical plant may have reached Marietta.

WORTHINGTON COLLEGE

The Ohio Reformed Medical College, or as it also was called, the Medical Department of Worthington College, had received its charter in 1829 but did not begin instruction until December, 1830. Dr. John Steele had come from New York to make arrangements for opening the college and he was its first president. Dr. Ichabod Gibson Jones, born in Maine, educated in Boston and New York, came also in 1830. He was a disciple of Wooster Beach and deeply interested in the reform movement. Shortly after his arrival Dr. John Steele resigned and Dr. Thomas Vaughn Morrow was brought in as president, and remained until the school went out of existence, when Morrow founded the Reformed Medical School of Cincinnati, the predecessor of the Eclectic Medical Institute.

The college represented a dream of educational progress in the town of Worthington, founded by James Kilbourne in 1803. Kilbourne, of Connecticut birth, had first married Mary Fitch, the daughter of John Fitch of Philadelphia, inventor of steam navigation. In 1808, the log cabin school which had first been built was moved to provide a site for the Worthington Academy. In 1817, Philander Chase having settled in Worthington, became president of the Worthington Academy and subsequently organized and obtained from the legislature a charter for Worthington College. Chase, however, was consecrated bishop at Philadelphia in 1819. As the "first miter of the West" he had little time for the Worthington College, instead forming the plan for a theological school, he obtained funds while vising England from Lord Gambier, Lord Kenyon and others and purchased 8,000 acres of land in Knox County founding Kenyon and Gambier Theological Seminary in 1826.

JAMES KILBOURNE OFFERS DR. BEACH A CHARTER

James Kilbourne having received a circular sent out by Wooster Beach, the founder of the Eclectic School of Medicine, who advertised the advantages to the West of such a school, offered the charter of the Worthington College, properly amended, for the purposes of a medical school. The trustees of Worthington College included some of the most respected citizens; Philander Chase, James Kilbourne, Thomas S. Webb, Chester Griswold, Recompense Stanberry, Chauncey Baker, Stephen Maynard, Ezra Griswold, Benjamin Gardiner, Orris Parrish, Lucas Sullivant and Leonard Cowles. The faculty before Riddell's arrival consisted of T. V. Morrow, Ichabod Jones and J. R. Paddock who had taught Latin in the academy and continued to do so in the college.

RIDDELL COMES TO WORTHINGTON

In the autumn of 1832 when Riddell arrived there were fifteen to twenty students. The college building was two storied and of brick painted red. It was ornamented by a cupola which protected the bell. That bell was saved when the building was torn down to make place for a high school and it is now in the high school building. The Journal of Riddell carries an entry dated Marietta, Sunday, August 26, 1832, in which he records:

"I have received an answer from Morrow of the O.R.M.C. and from what he says I might probably lecture there. The term commences the first Monday in October. The lectures at Cincinnati commence the first Monday in November. I have commenced writing my botanical report and it pleases me."

There were really thus but two men at that time in the Worthington College with medical degrees, Jones and Morrow. Rensselaer had added an A.M. to the A.B. when Riddell had applied through Amos Eaton for it. But Riddell needed a medical degree and he took notes on the lectures by Morrow on obstetrics and by Jones on materia medica. He assembled and prepared his apparatus and reagents for his chemistry course. He also had time for collecting and drying plants and preparing the herbaria he was so eager to sell or to exchange with others. In tramping around in the ravines cut through the shale banks by the numerous little streams which are tributary to the Olentangy River he remarked on the concretions those almost spherical masses which vary in size from a tennis ball to a bushel basket. He wrote an article in the paper about them. He also wrote about a shower of meteors which occurred during that autumn.

DIFFICULTIES IN THE STUDY OF ANATOMY

All of the members of the school faculty were young. Morrow was 28 and Jones and Riddell born in the same year were five years younger. They were ready to fight for reform. Riddell, however, not having a medical degree was outside of their circle and he was, as usual bored. He was also a little troubled by the grave robberies which the anatomy students were obliged to practice. An entry of December 8, 1833, reads: "The students went after a subject last night and failed because they could not find the grave."

His father had died earlier in the year and he was depressed by the thought that his mother and her large family were struggling and he was unable to help them. As with other imaginative people when depressed he became inactive. The following illustrates the point:

6 Evening. A dark dreary night. The students are about to go off and rob a negro's grave. I hope they may succeed. Tebbs and others say they saw a Jack-o-Lantern last night. It appeared two rods from them. The light was pale and lambent. I give no attention to botany now. Should I be spared another season, of course, I shall either remain here or try my fortune somewhere else. Should I remain here and have leisure. I will engage myself in writing my intended treatise on botany. I do not mean the Western Flora.

What he apparently had in mind was a taxonomic work. He also wanted to improve himself in Latin and in Greek and go to a professorship in Cincinnati or in Louisville.

THE "UNIVERSITY OF INDIANA AT NEW ALBANY"

There were two interests, however, that developed during part of 1833 and the spring of 1834 before he left for Cincinnati. John Cook Bennet who had kept in touch with Riddell since he had become acquainted with him in Pittsburgh, or even earlier, offered a degree of L.L.D. to Riddell and a professorship with popular courses on botany and chemistry besides. In a

prospectus the college was called the *"Medical College of Indiana"* and also the *"University of Indiana at New Albany."* Bennet also advertised that he had a charter from the legislature. This, however, was for the Christian College at New Albany, and as soon as the charter was challenged the New Albany newspapers carried the following notice: "Ordinance No. 4. 'Be it ordained by the Christian College that the Christian College is the name of the Corporation or Trustees of the University located at New Albany, Indiana only and not of the University itself." The degree was spurious, Bennet, an impostor, who called himself at various times President, Doctor, Chancellor or Bishop, claimed also a $200,000 insurance company operated by the college. Bennet never visited Worthington but always arranged to have Riddell come to Columbus to meet him. As soon as he was convinced that the whole affair was fraudulent and the college non-existant he became even more preplexed about medical colleges and their ways and resolved to leave Worthington. His attitude even to Jones and Morrow became distant as though they had helped to expose him to injury. Except for this he would probably have obtained a degree at Worthington and remained there.

His other interest was romantic. He fell in love with Mary Catherine Burr. At the wedding of Ichabod Jones to Cynthia Kilbourne, who was the daughter of James Kilbourne and Cynthia Goodale, James' second wife, Catherine had been bridesmaid and Riddell had danced with her and was pointed out as a likely suitor. He had called on her and they met at church where her brother, Rev. George Burr, sometimes conducted the services before he left Worthington for Kenyon College. Catherine's window was visible from the room where Riddell slept and when she was prepared to meet Riddell she sometimes placed a lighted candle in the window. Or did Riddell just imagine that? At least he called on her father and mother. He met Mary Catherine at tea. By judicious inquiry around the town about the Burr family he learned that she owned some property. He then hesitated to tell her of his own poverty:

> So at length I told her that my father had died and left his family in embarrassed circumstances; that I was the oldest and had young brothers and interesting little sisters, that I must be their protector; that I could not consent to entail embarrassment on her for I had heard she had a thousand dollars or so left her by an uncle.
>
> The candle had gone out but from our position I discovered her face was bathed in tears. She owned my feelings were correct, said that we could remain as we were until I had discharged my duty to my mother's family, that I had known little of her feelings if I had supposed that such a disclosure would lessen her affection. Her uncle left her a farm of 300 acres situated some sixty miles north of this place. She was exceedingly glad I had chosen to confide these matters to her and at my request assured me she would inform no one, not even her mother. I shall see her again a week from Monday.

In a collection of memorabilia of John Riddell's donated to the Howard-Tilton Memorial Library along with the personal Journal, is a lock of blond hair labeled in Riddell's unmistakable handwriting, "Lock of hair from Mary Catherine Burr, now Mrs. Ufford." How this romance died down one can only guess. Riddell left Worthington to attend medical lectures in Cincinnati. No mention in the Journal is made that any correspondence ensued.

CORRESPONDENCE WITH CHARLES WILKINS SHORT

During the spring, he resumed his plant collections and he exchanged notes with Dr. Hildreth, with Dr. Short and prepared a package of plants to send to Dr. Drake. The idea of a medical degree for the time being had been banished and the coolness between himself and his colleagues was troubling him. He had an A. M. but it was clear that there was no future in Worthington for him without an M.D. degree. He must have collected or made some good chemical apparatus[9] as Rev. Creighton of Lithopolis avers, and students liked his lectures. It was, however, time for him to make a change. He talked with Morrow and suggested that as Mr. Paddock could give lectures in botany he would not be needed during the summer. He was told that Jones and Morrow had thought of that. This was tantamount to accepting his resignation. In a letter dated March 5, 1834, to Col. George Boyd of Marietta he mentions that Mrs. Burr, Mary Catherine's mother, had died and continues: "Inform Dr. Hildreth if you please that I have procured an antique skull from a mound in Columbus and I shall be happy to forward this to him if he wishes. It is rather in fragments . . . In the month of April I shall undoubtedly take leave of Worthington, whether that leave will be temporary or final I cannot say."

His stay in Worthington had benefited him as a collector and naturalist even if he had not been given a medical degree. He was able to list some 700 plants in the *Catalogue of Franklin County,*[10] when he wrote it at Cincinnati in the next few months. He also had made some contributions to geology. With Dr. Hildreth, he shared the honor of being one of our earliest archaeologists. Central Ohio had added to Riddell's mental stature in a number of ways. Though he did not indulge in medical controversy, he must have learned about the Reformed School and how it differed from the allopaths and the homeopaths. It was this didactic spirit in medicine that kept his interest in science alert. He decided to accept Hildreth's advice and go to Cincinnati.

(To be continued)

Better Get Your Hotel Room At Once for Annual Meeting May 7, 8, 9, Columbus; Good Space Selling Rapidly

THERE is still a relatively great amount of choice in regard to hotel accommodations for the Centennial Anniversary Meeting of the Ohio State Medical Association, May 7, 8, and 9, in Columbus . . . but the desirable rooms are dwindling fast.

In order to assure that you will have comfortable quarters near the activities of the session, request your reservations **immediately.** Look over the accompanying hotels and send the reservation blank below to the management of the hotel you select.

The program of the State Meeting will be conducted at both the Neil House and the Deshler-Wallick Hotel, Columbus.

NAME AND LOCATION	No. of Rooms	Single	Double	Double Twin Beds	Suites
NEIL HOUSE 35 South High St.	665	$4.40-7.70	$5.00-9.00	$5.50-11.00	Rates on request
DESHLER-WALLICK Broad and High Sts.	1000	3.30-8.80	5.50-11.00	5.50-13.20	Rates on request
FORT HAYES 31 W. Spring St.	350	3.00 and up	4.50 and up	5.00 and up	7.00-20.00
CHITTENDEN High and Spring Sts.	275	2.00-3.00	3.00-4.00	3.50-6.00	
SENECA 361 E. Broad St.	250	2.50-4.00	4.00-5.00	5.00-6.00	8.00-12.00
SOUTHERN High and Main Sts.	250	2.50-3.00	3.50-4.00	4.00-4.50	
VIRGINIA Third and Gay Sts.	150	2.20 and up	3.30 and up	4.40 and up	
BROAD-LINCOLN 631 E. Broad St.	140	2.20 and up	3.30 and up	4.95 and up	3.85 and up

HOTEL RESERVATION BLANK

Mail this coupon to hotel selected

Manager _____ Hotel, Columbus, Ohio.

You are requested to reserve the following accommodations during the period of the Centennial Anniversary Meeting of the Ohio State Medical Association, May 7, 8 and 9, 1946, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double room with bath Price: _____

☐ Twin Bed Room with bath ☐ Suite

Arriving May _____ at _____ A. M. _____ P. M.

PLEASE VERIFY MY RESERVATION.

Name _____

Address _____

_____

Expansion of Public Relations Program and Additional Service Planned by Council if House of Delegates Approves Increase in State Association Dues

EDITOR'S NOTE: *The following statement by The Council of the Ohio State Medical Association was prepared after consultation with the Committee on Public Relations and the Executive Secretary and was ordered published in The Journal for the information of the entire membership prior to the sessions of the House of Delegates, May 7, 8, and 9, 1946, when action will be taken on the matter of increasing the annual per capita dues of the Association.*

WHEN the House of Delegates of the Ohio State Medical Association meets in Columbus at the time of the Centennial Anniversary Meeting of the Association, May 7, 8, and 9, 1946, The Council of the Association will recommend that the House of Delegates authorize an increase in the per capita annual dues of the Association, effective January 1, 1947. Present dues of the Association are $7.00 per annum. The Council will recommend that the dues, effective January 1, 1947, shall be $15.00.

This decision of The Council was made on December 16, 1945, after due deliberation and after hearing recommendations of the Committee on Auditing and Appropriations which had made a careful survey of reasons for expanding and extending the activities and services of the Ohio State Medical Association and various steps which should be taken to accomplish this objective.

OFFICIAL ACTION OF COUNCIL

The following quotation from the official minutes of the December 16 meeting of The Council presents in a general way the attitude of The Council and the reasons for its action in recommending an increase in the annual dues:

> "Dr. Rutledge reported that the committee had given very serious and lengthy consideration to the matter of providing proper funds for extension of the activities of the Association, especially in the field of public relations. He stated that the committee felt the public relations program of the Association must be expanded through the use of radio, literature to the lay public, newspaper publicity and advertising, if necessary, enlargement of a speakers' bureau and other activities. The committee stated that the Association would be unable to carry out a contemplated constructive program for improvement in the medical and health services and facilities in Ohio within its present budget and that it would be unable to take more vigorous action in combating efforts being made to regiment and socialize the medical profession unless more funds are provided for necessary activities of this kind.
>
> "Therefore, Dr. Rutledge reported that the committee recommended to The Council that it in turn recommend to the House of Delegates, which will meet May 7, 8, and 9, 1946, that the House of Delegates authorize an increase in the annual dues of the Ohio State Medical Association to make the annual dues $15.00 effective January 1, 1947."

This decision of The Council is based on a realization that the Ohio State Medical Association must be geared to keep pace with new problems and increasing responsibilities confronting the medical profession.

Machinery which was set up to represent the medical profession of Ohio 100 years ago this coming May—that which existed 50 years ago, 25 years ago, even five years ago—is not adequate to do the job which must be done now, next year, and in succeeding years.

Members of the Ohio State Medical Association want their society to be an increasingly progressive and aggressive organization. They want it to do an increasingly better job; to provide additional services.

It will be possible for the Association to attain these goals if it has a satisfactory budget, based on adequate current income.

WHAT CAN BE DONE

If the annual dues are increased as recommended by The Council, the Association will be in a position to take on new activities and extend its present activities along the following lines:

1. A properly financed and adequately manned Department of Public Relations can be maintained. To date, the public relations of the medical profession have been spotty and inadequate, largely because of a shortage of personnel and insufficient funds. Correction of this weakness is long overdue. An effort to build up this important phase of the work of medical organization should not be delayed.

Given sufficient funds, the Department of Public Relations will be able to carry on an extensive program of public education through the radio and the press, using paid time and space, if necessary, to present the medical profession's

views on important legislative, economic, and social questions affecting public health and the practice of medicine.

Occasions may arise when it will be necessary for the Ohio State Medical Association to engage the services of competent outside public relations counsel on a consultation basis. These services will cost money but, if considered necessary, should be obtained.

2. In order to substantiate its views on questions of public interest, the Association must be in possession of accurate data—for example, data on the distribution and adequacy of medical personnel and facilities in Ohio. Surveys to get this information may have to be made—in all probability will have to be made—at the expense of the Association.

3. More field work among the county medical societies and closer contact with the district societies is imperative. Members of The Council can not be expected to devote full time, even part time, to this important activity. The job can not be done adequately now from the Columbus office with its limited personnel. Some increase in personnel for field work is indicated.

4. A more extensive postgraduate education program than that which has been carried on by the Association in the past should be inaugurated, not only for the benefit of returning medical officers but to provide opportunities for refresher and review work for other physicians who did not have a chance to take such courses during the war.

5. One of the most important activities in which the Association will engage during the coming years will be to guide and direct an adequate program of medical care for disabled veterans. This activity will require the Association to assume important responsibilities. To meet these, the Association may find it necessary to engage additional personnel and to establish added facilities in the Columbus office.

6. With an increase in legislative and administrative questions affecting the medical profession as a whole and physicians individually, the Association is finding it increasingly necessary to secure the services of competent legal counsel. In the past, expenses for occasional legal counsel have been absorbed in the budget under general items. If the need for legal counsel increases, and it doubtless will, provision for such expenses should be established in the regular annual budget.

7. Costs of operating the Columbus office, including the costs of printing, postage, supplies, and equipment, have increased. These costs will continue to increase.

8. There is a need for more direct-mail contact with the members of the Association. The Ohio State Medical Journal endeavors to keep the members informed of current questions of interest. However, being a monthly publication, it can not be used as a medium for "spot" bulletins and memoranda on unexpected developments. Efforts should be made to produce bulletins, pamphlets, and digests for the information and use of all members. If this is done properly, printing and postage costs will be substantial.

9. At an early date, the Speakers' Bureau of the Association should be reorganized to provide competent speakers for medical and lay meetings. This will require some additional expense on the part of the Association.

COMPARISON WITH OTHER STATES

The question has been asked: How do the present dues of the Ohio State Medical Association compare with those of other state medical societies?

A tabulation of the per capita dues charged by 43 state medical societies, including Ohio, shows Ohio, with present dues of $7.00, well towards the bottom of the list.

Thirty-five state medical societies, including those representing states comparable to Ohio in population, wealth, industry, and number of physicians, charge annual dues which are larger than present dues in Ohio. Seventeen of these 35 charge dues greater than $15.00 which The Council is proposing for the Ohio State Medical Association.

For example, the total of per capita dues and assessments of some of the adjoining and most progressive state medical societies are as follows: Michigan, $37.00; Pennsylvania, $20.00; Indiana, $15.00; Minnesota, $20.00; West Virginia, $15.00; Texas, $20.00; Wisconsin, $33.00; Connecticut, $20.00; District of Columbia, $30.00; Iowa, $15.00; Kansas, $15.00; Missouri, $15.00; Nebraska, $15.00. In California, the per capita dues amount to $100.00. Two state societies charge annual dues of $7.00, the same as Ohio is now charging; five state societies, all of them quite small societies, have dues less than Ohio's.

ACTION DEPENDS ON CURRENT INCOME

It would be unwise and foolhardy for the Association to attempt to finance additional activities on more than a temporary basis by the use of its reserve funds. Current activities must be geared to current income if the Association expects to remain solvent. The reserve funds are set aside for a specific purpose, i. e., to meet emergencies, and they should be preserved solely for that purpose. Incidentally, as most members know, $35,000 of the reserve funds of the Association were used during 1945 for the purchase of the common stock of Ohio Medical Indemnity, Inc. This was done to give the medical profession of Ohio the control of the company which was organized through the initiative of the Ohio State Medical Association to carry on a voluntary prepaid medical, surgical, and obstetrical

program in Ohio—a program demanded by many Ohio citizens.

Therefore, in the opinion of The Council and many others who recognize the value of maintaining a strong, progressive state organization to represent the medical profession of Ohio, it would be wise and far-sighted for the House of Delegates to approve the increase in dues as recommended. This will enable the Association to start its second 100 years on a sound basis and with a program adequate to meet the needs and demands of the times.

Tournament on May 6 Planned By Ohio State Medical Golfers' Association

For the first time since the Cincinnati Annal Meeting in May, 1940, the Ohio State Medical Golfers' Association is planning a tournament. Prior to the war, this was an annual affair held the day before the opening of the Ohio State Medical Association's scientific meeting. At the 1941 A.M.A. Meeting in Cleveland, "Bill" Burns and his A.M.A. group took over the golf tournament. Since then, no formal tournament has been arranged.

This year, with the meeting in Columbus, May 7, 8, and 9, the Golf Association's officers plan to have a tournament on Monday, May 6, 1946—**if arrangements can be made for a golf course and banquet.**

Every member of the Ohio State Medical Association is eligible to participate in the tournament. The O.S.M.G.A. is an organization for pleasure only—and golf in particular.

Further announcement will be made in the April issue of *The Journal.* Officers of the Golf Association are: President, E. C. Yingling, M.D., Lima; first vice-president, D. C. Brennan, M.D., Akron; second vice-president, Valloyd Adair, M.D., Lorain; third vice-president, J. J. Marek, M.D., Cleveland; fourth vice-president, R. E. Hatfield, M.D., Cincinnati; fifth vice-president, T. H. Brown, M.D., Toledo; secretary-treasurer, George W. Cooley, Toledo.

Indiana Adopts Voluntary Plan

Another voluntary prepayment medical care plan was added to the list on January 27, when the House of Delegates of the Indiana State Medical Association authorized the creation of the Mutual Medical Insurance, Inc., a non-profit indemnity company organized under the statutes of the State and to be controlled by the members of the medical profession. The plan was adopted after three years of study and discussion, and will be financed by contributions from physicians and other interested persons. Paid in capital of $65,000 is required and the company will write medical and surgical insurance on a group basis.

WOULD YOU BE INTERESTED IN SPECIAL TRAIN TRIP TO SAN FRANCISCO?

POSSIBILITIES of running an "Ohio State Medical Association Special Train" to San Francisco for the 1946 Annual Session of the American Medical Association, July 1-5, are being explored by the Columbus office of the Association.

Many will remember the successful all-expense special train tour through the West which was sponsored by the Ohio State Medical Association in 1938 at the time of the last A.M.A. session in San Francisco.

At present it is impossible for the railroads to make definite commitments and the same situation prevails with respect to hotels, national parks, and other places of entertainment and interest. However, the matter is being checked and an announcement, yes or no, will be made at the earliest possible date.

Would you be interested in joining a special train party if satisfactory railroad accommodations and an interesting itinerary can be arranged?

If so, drop a card to the Columbus office so that it can get in touch with you directly if and when more definite information is available.

Two New Department Heads Named At U. of C. Medical School

Appointment of two new department heads in the College of Medicine has been announced by the Board of Directors of the University of Cincinnati.

Dr. Burr Noland Carter, a member of the faculty since 1922, was named professor of surgery, succeeding the late Dr. Mont R. Reid. During the war, Dr. Carter was assistant to the chief surgical consultant in the office of the Surgeon General, with the rank of colonel.

The new head of the department of anatomy is Dr. Joseph Louis Schwind, formerly on the faculty of Albany Medical School, Union University, Albany, N. Y. He succeeds Dr. Edward F. Malone, resigned.

Dr. Albert B. Sabin, a member of the U. C. staff since 1939, has been promoted from associate professor to full professor of research pediatrics. Dr. Sabin was a lieutenant colonel in the Medical Corps, with duty in the office of the Surgeon General's Army Epidemiological Board, Preventive Medicine Service.

Distinguished Group of Guest Speakers Will Participate In Centennial Meeting of Association, May 7, 8, and 9

ON the cover of this issue appear photographs of the eight out-of-state guest speakers who will participate in the Centennial Meeting of the Ohio State Medical Association, May 7, 8, and 9, Columbus.

The complete program of the meeting, which will be divided between the Neil House and Deshler-Wallick Hotel, will be published in the April issue of *The Journal.* This first post-war program will be packed with valuable information and opinion concerning post-war medicine. No member of the Association can afford to miss it. The meeting will open at 10:00 A.M., May 7, and close at noon on May 9.

Following are thumb-nail sketches of the guest speakers:

William H. Feldman, D.V.M., D. Sc. (Hon.), Rochester, Minnesota, is professor of comparative pathology, Mayo Foundation of the Graduate School, University of Minnesota; and member of the American Association of Pathologists and Bacteriologists, Minnesota Pathological Society, American Trudeau Society, and American Society for Experimental Pathology. Dr. Feldman will address the general session at 3:45 p.m., Wednesday, on the subject, "Evidence of Therapeutic Effects of Streptomycin in Experimental Turberculosis".

Philip D. Jordan, Ph.D., Minneapolis, Minnesota, associate professor of history, University of Minnesota; former associate professor of history, Miami University, Oxford; editor, *Mississippi Valley Press;* author, *William Salter—Western Torchbearer, Ohio Comes of Age, Singin' Yankee,* and many articles on the history of medicine. Dr. Jordan will address the banquet session on the subject, "Forever as He Rides".

Roy D. McClure, M.D., Detroit, surgeon-in-chief, Henry Ford Hospital, Detroit; extramural lecturer, University of Michigan, Ann Arbor; member of the American Surgical Association, American Medical Association, Central Surgical Association, Southern Surgical Association; Fellow, American College of Surgeons; member, Society International Chirurgie. Dr. McClure's address is scheduled for 2:30 p.m., Wednesday, at the general session. He will speak on "The Surgical Treatment of Bleeding Peptic Ulcer".

Brig. Gen. William C. Menninger, M.D., Washington, D.C., director of the Neuropsychiatry Consultants Division, Office of the Surgeon General, U.S. Army; Fellow, American Medical Association; member, American Psychiatric Association; Fellow, American College of Physicians; member, American Orthopsychiatric Assocation, American Psychoanalytic Association, American Psychopathological Association, Central Neuropsychiatric Association, Association for Research in Nervous and Mental Disease, Central Society for Clinical Research; recipient of Lasker Award from National Committee Mental Hygiene, 1944. General Menninger will address the general session at 4:45 p.m., Wednesday, on the subject, "Readjustment of the Disabled Veteran to Civilian Life".

Carl V. Moore, M.D., St. Louis, associate professor of medicine, Washington University School of Medicine, St. Louis; member of American Society of Clinical Investigation, Central Society for Clinical Research, American Institute of Nutrition, American Society of Experimental Pathology; Fellow, American College of Physicians. Dr. Moore will address the general session at 3 p.m., Wednesday, on the subject, "Recent Advances in the Understanding and Therapy of Anemias".

Walter Lincoln Palmer, M.D., Chicago, professor of medicine, University of Chicago; chief of the division of gastrointestinal diseases, Albert Merritt Billings Hospital, University of Chicago; Fellow, American College of Physicians; member of the American Gastroenterological Association, American Society for Clinical Investigation, Association of American Physicians, Central Society for Clinical Research, Society of Internal Medicine, Society for Experimental Biology and Medicine, and Sigma Xi. Dr. Palmer will address the general session at 2 p.m., Wednesday, on the subject, "Medical Management of Gastrointestinal Disturbances".

Stanley P. Reimann, M.D., Philadelphia, director, Research Institute, Lankenau Hospital, Philadelphia; director, Institute for Cancer Research, Lankenau Hospital; associate professor, surgical pathology, University of Pennsylvania Graduate School of Medicine; professor of oncology, Hahnemann Medical School; member, American Society of Clinical Pathologists, American Association for Cancer Research, and American Society of Experimental Pathology. Dr. Reimann will talk at 9 p.m., Tuesday, during the general session. His subject will be "Present Status of Cancer Research".

Homer F. Swift, M.D., New York City, member of the Rockefeller Institute for Medical Research, and physician to the hospital of the Rockefeller Institute. Dr. Swift will address the general session at 2 p.m., Tuesday, on the subject, "Relationship Between Rheumatic Fever and Hemolytic Streptococcal Infections".

National Health Program Adopted by A.M.A.; Provides for Development and Coordination of Voluntary Prepaid Medical Care Plans and Extended Health Services

THROUGH definite action taken during the week of February 11, the American Medical Association adopted a constructive and forward-looking national program for the improvement of medical care and extension of health services.

At a meeting in Chicago, the Board of Trustees and the Council on Medical Service and Public Relations of the A.M.A. took the following official actions on behalf of the American Medical Association:

1. Adopted a plan which provides for development and extension of voluntary prepayment plans under the guidance of the American Medical Association to give the American people opportunities to protect themselves against the costs of sickness.

2. Establish standards of acceptance for voluntary medical care plans which have the aproval of the Council on Medical Service and Public Relations of the A.M.A.

3. Endorsed the organization of a voluntary federation known as Associated Medical Care Plans, Inc., which will undertake to establish coordination and reciprocity among its member plans which must meet the minimum standards referred to above.

4. Established under the Council on Medical Service and Public Relations a Division of Prepayment Medical Care Plans with a director and a staff who will administer the activities of the Council related to the promotion and development of medical care plans in all of the states.

5. Revised the "Constructive Program of the American Medical Association for the Improvement of Medical Care" so as to extend and amplify policies in the development of services in the fields of preventive medicine, maternal and child health, voluntary prepayment plans, compensation for loss of wages due to illness, and the care of the veteran, and in improvement of standards of housing, nutrition, clothing and recreation.

One of the important steps in the development of the above plan was the establishment of standards of acceptance for medical care plans. Any plan which meets the standards of the Council will be entitled to display the seal of acceptance of the American Medical Association on its policies and on all of its announcements and promotional material.

In order to qualify for acceptance, the prepayment plan must have the approval of the state or county medical society in the area in which it operates. The medical profession in the area must assume responsibility for the medical services included in the benefits.

Plans must provide free choice of a qualified physician and maintain the personal, confidential relationship between patient and physican. The plans must be organized and operated to provide the greatest possible benefits in medical care to the subscriber.

Medical care plans may be in terms of either cash indemnity or service units, with the understanding that benefits paid in cash are to be used to assist in paying the costs incurred for medical service. The standards also include provisions relative to the actuarial data that are required, systems of accounting, supervision by appropriate state authorities, and periodic checking and reporting of the progress of the plan to the Council.

NATIONAL AGENCY ORGANIZED

The voluntary independent federation, known as Associated Medical Care Plans, Inc., will include as members all plans that meet the minimum standard of the Council on Medical Service and Public Relations of the American Medical Association and will undertake to establish coordination and reciprocity among all of these plans so as to permit transference of subscribers from one plan to another and use of the benefits in any state in which a subscriber happens to be located.

Under this method great industrial organizations with plants in various portions of the

United States will be able to secure coverage for all of their employees.

Moreover, it will be possible for the Veterans Administration, welfare and industrial groups, as well as government agencies, to provide coverage for the people in any given area through a system of national enrollment.

In addition, the Associated Medical Care Plans, Inc., will undertake research and the compilation of statistics on medical care, provide consultation and information services based on the records of existing plans, and engage in a great campaign of public education as to the medical service plan movement under the auspices of state and county medical societies.

Impetus to the development and extension of medical care plans will result from the establishment of the Division of Prepayment Medical Care Plans with a director and a staff.

NEW NATIONAL PROGRAM ADOPTED

By restating in revised fashion the 14-point program of the American Medical Association, originally adopted by the Council on Medical Service and Public Relations in June, 1945, and endorsed by the House of Delegates in December, 1945, the Board of Trustees clarified some of the A.M.A. policies on public health questions and brought the program into line with new developments and additional public needs.

The revised "National Health Program of the American Medical Association", based on action taken the week of February 11 is as follows:

1. The American Medical Association urges a minimum standard of nutrition, housing, clothing, and recreation as fundamental to good health and as an objective to be achieved in any suitable health program. The responsibility for attainment of this standard should be placed as far as possible on the individual, but the application of community effort, compatible with the maintenance of free enterprise, should be encouraged with governmental aid where needed.

2. The provision of preventive medical services through professionally competent health departments with sufficient staff and equipment to meet community needs is recognized as essential in a health program. The principle of Federal aid through provision of funds or personnel is recognized with the understanding that local areas shall control their own agencies as has been established in the field of education. Health departments should not assume the care of the sick as a function since administration of medical care under such auspices tends to a deterioration in the quality of the service rendered. Medical care to those unable to provide for themselves is best administered by local and private agencies with the aid of public funds when needed. This program for national health should include the administration of medical care including hospitalization to all those needing it but unable to pay, such medical care to be provided preferably by a physician of the patient's choice with funds provided by local agencies with the assistance of Federal funds when necessary.

3. The procedures established by modern medicine for advice to the prospective mother and for adequate care in childbirth should be made available to all at a price that they can afford to pay. When local funds are lacking for the care of those unable to pay, Federal aid should be supplied with the funds administered through local or state agencies.

4. The child should have throughout infancy proper attention including scientific nutrition, immunizatiin against preventable disease, and other services included in infant welfare. Such services are best supplied by personal contact between the mother and the individual physician but may be provided through child care and infant welfare stations administered under local auspices with support by tax funds whenever the need can be shown.

5. The provision of health and diagnostic centers and hospitals necessary to community needs is an essential of good medical care. Such facilities are preferably supplied by local agencies, including the community, church, and trade agencies which have been responsible for the fine development of facilities for medical care in most American communities up to this time. Where such facilities are unavailable and can not be supplied through local or state agencies, the Federal government may aid, preferably under a plan which requires that the need be shown and that the community prove its ability to maintain such institutions once they are established. (Hill-Burton bill)

6. A program for medical care within the American system of individual initiative and freedom of enterprise includes the establishment of voluntary nonprofit prepayment plans for the costs of hospitalization (such as the Blue Cross plans) and voluntary nonprofit prepayment plans for medical care (such as those developed by many state and county medical societies). The principles of such insurance contracts should be acceptable to the Council on Medical Service of the American Medical Association and to the authoritative bodies of state medical associations. The evolution of voluntary prepayment insurance against the costs of sickness admits also the utilization of private sickness insurance plans which comply with state regulatory statutes and meet the standards of the Council on Medical Service of the American Medical Association.

7. A program for national health should include the administration of medical care, including hospitalization, to all veterans, such medical care to be provided preferably by a physician of the veteran's choice with payment by the

Veterans Administration through a plan mutually agreed on between the state medical association and the Veterans Administration.

8. Research for the advancement of medical science is fundamental in any national health program. The inclusion of medical research in a National Science Foundation, such as proposed in pending Federal legislation, is endorsed.

9. The services rendered by volunteer philanthropic health agencies such as the American Cancer Society, the National Tuberculosis Association, the National Foundation for Infantile Paralysis, Inc., and by philanthropic agencies such as the Commonwealth Fund and the Rockefeller Foundation, and similar bodies have been of vast benefit to the American people and are a natural outgrowth of the system of free enterprise and democracy that prevail in the United States. Their participation in a national health program should be encouraged and the growth of such agencies when properly administered should be commended.

10. Fundamental to the promotion of the public health and alleviation of illness are widespread education in the field of health and the widest possible disseminaton of information regarding the prevention of disease and its treatment by authoritative agencies. Health education should be considered a necessary function of all departments of public health, medical associations, and school authorities.

Literature on Epilepsy

Latest facts on the medical and psychological treatment of epilepsy are now available to physicians through the American Epilepsy League, Inc., according to Esther C. Walther, executive secretary of the organization. A partial list of the literature available to physicians and others includes: "The Treatment of Epilepsy", "Marriage and Children for Epileptics", "Employment of Epileptics", "The Epileptic: Who He Is, What He Can Be", "Building a Future for the Epileptic Child", and "Epilepsy and the Public Health Nurse". Address of the League is: Room 405, 50 State Street, Boston 9, Massachusetts.

Art Contest for Physicians

The American Physicians' Art Association prize contest dealing with the subject "Courage and Devotion Beyond the Call of Duty" will be judged at the 1947 Session of the American Medical Association. Originally scheduled for this year, the contest has been postponed in order to give physicians more time to complete their exhibits, which will compete for $34,000 in Savings Bonds. According to Mead Johnson & Co., the sponsor, a regular art exhibit has been scheduled for this year in lieu of the contest.

WAGNER - MURRAY - DINGELL BILL HEARINGS TO START ON MARCH 18; SEND SEN. TAFT YOUR VIEWS NOW

Hearings on the newest version of the Wagner-Murray-Dingell Bill, S. 1606, proposing to establish the Truman National Health Program, including a gigantic system of compulsory sickness insurance, will start before the U. S. Senate Committee on Education and Labor on March 18.

Senator Robert A. Taft of Ohio is a member of the committee of which Senator Murray, one of the authors of the proposal is the chairman.

It is suggested that physicians write to Senator Taft, Senate Office Building, Washington, D. C., expressing their opinion of S. 1606, and have their friends, acquaintances and patients do so. Senator Taft has expressed himself as believing S. 1606 is unworkable, too costly and objectionable in many respects. Nevertheless, write him.

Tell him about the new National Health Program of the American Medical Association (which is reviewed on pages 277-279).

Refer to Ohio Medical Indemnity, Inc., the voluntary prepaid medical care plan sponsored by the Ohio State Medical Association and now enrolling subscribers.

Remind him that similar plans are operating in many of the states and are being organized in other states.

Reassure him that, in your opinion, Ohio the fourth wealthiest state in the union, can, and will, see that Ohio citizens are provided with necessary health and medical services.

Act now!

Publish Cancer Series

In connection with the program of the American Cancer Society, Inc., a series of articles on cancer will appear in the following issues of current national magazines: *Reader's Digest* for March; *Science Illustrated* for April; *Look* for April 10; and *Everybody's Digest* for May. Articles appeared in the January 20 *American Weekly;* the February issue of *Tomorrow Magazine;* and in the February 23 *Collier's.*

Work of Procurement and Assignment Service in Ohio To Terminate April 1, Chairman Conard Announces

OHIO'S Procurement and Assignment Service for Physicians will terminate its activities on or about April 1, it has been announced by Dr. Robert Conard, Wilmington, who has served as chairman of the Ohio agency since early in 1942.

Created as a war agency, the Procurement and Assignment Service has limited its activities since V-J Day to assisting hospitals and medical schools to reconvert from the 9-9-9 program relating to students, interns, and residents to regular peacetime procedures and to assisting in the important job of securing physicians for areas with an acute shortage of medical personnel.

The reconversion of the 9-9-9 program is well on the way to completion. By April 1, practically all commissioned residents now serving in civilian hospitals will have been called to active duty, enabling the armed forces to release many medical officers who entered the services from civilian practice.

By that time, most hospitals will have an increased number of civilian residents and the prewar 12-months July-to-July period for internships and residencies will have been re-established. Also, as of that date all Procurement and Assignment Service intern and resident quota restrictions will have been lifted.

SHOULD CONTACT SURGEONS GENERAL

After April 1, it is expected that any necessary correspondence relating to deferments, calls to active duty, or related matter will be conducted by hospitals directly with the Surgeons General.

As of February 15, the Washington office of the Procurement and Assignment Service terminated intervention with the Surgeons General for the purpose of securing the release of a medical officer for practice in an acutely needy area. All requests of this kind which had been filed with the Washington office by that date will be acted upon but no requests received after February 15 will be considered. The Surgeons General have been advised of this.

The Ohio State Medical Association, through its Headquarters Office, Columbus, will continue with the work of listing areas needing physicians and of endeavoring to persuade physicians seeking locations to open a practice in such areas. Also, it will continue to supply returning medical officers with information on opportunities for postgraduate training.

STATEMENT BY CHAIRMAN CONARD

In announcing the termination date of Procurement and Assignment Service activities in Ohio, Dr. Conard issued the following statement:

"During the past four years, the Ohio Procurement and Assignment Committee has been faced with many complicated problems and has had to make many vital decisions. Our work has not been perfect, but we have made at all times a sincere effort to be fair and reasonable, basing our decisions on the facts in each case as obtained by or presented to us.

"As chairman I have had the finest cooperation and help at all times from members of the state committee, members of local committees, deans of Ohio's medical schools, hospital administrators, officials of the Ohio State Medical Association, members of the Columbus office staff, and many others who have been directly or indirectly interested in the work of the Procurement and Assignment Service.

DOCTORS PRAISED FOR FINE SPIRIT

"Our work was not nearly as difficult as it might well have been because of the attitude shown by all but a comparatively few of the several thousand Ohio physicians who gave up civilian practice, at a great sacrifice, to enter military service.

"Moreover, a fine spirit of cooperation and patriotism has been displayed by the people of Ohio who for the most part accepted curtailed medical services during the war in order that those in the services could have the best medical service any Army has ever had in all history of warfare. Recognition also must be given to those older physicians and to those who were rejected for military service who served so faithfully in supplying the medical needs of civilians during the war.

"At home as well as in the field, Ohio medical men met the crucial test of the war years with courage and resolution in the best tradition of the profession."

Publishers Will Award $3,500

The book publishing firm of W. W. Norton & Company is again inviting manuscripts to be considered for the Norton Medical Award of $3,500 offered to encourage the writing of books on medicine and the medical profession for the layman. Closing date for submission of manuscripts this year is November 1. Particulars relating to requirements and terms may be obtained from the company. Address, 70 Fifth Avenue, New York 11, N. Y.

Cincinnati—At a dinner-meeting of the Cincinnati Council of Childhood Education, Dr. Clarence A. Mills gave an address on "The Physical Basis of Mental Ability".

Initial Plans Laid for Ohio Program To Furnish Medical Care to Veterans Through Doctors in Private Practice

PROVISIONS for an Ohio program whereby veterans with service-connected disabilities who are eligible for medical care at the expense of the government through the Veterans Administration may receive services from physicians in private practice are being worked out by the Committee on Medical Care of Veterans of the Ohio State Medical Association.

Recommendations of the committee will be submitted to The Council of the State Association in the near future. After the suggested program has been approved by The Council, it will be submitted to the Veterans Administration for consideration and approval.

The initial steps on this matter were taken at a meeting of the Committee on Medical Care of Veterans, Sunday, February 3, in Columbus.

At that meeting, Dr. Harry V. Paryzek, Cleveland, chairman of the committee, made a report on a conference which he and Mr. Nelson, executive secretary, had with Maj. Gen. Paul R. Hawley, medical director, Veterans Administration, in Washington, D.C., on January 16.

REPORT ON HAWLEY CONFERENCE

General Hawley at the Washington conference reiterated the desire of the Veterans Administration, previously expressed in writing, that the Ohio State Medical Association develop a program for Ohio which would enable veterans with service-connected disabilities to obtain services from physicians in their home communities on a fee-for-service basis. General Hawley suggested that the Assocation submit a suggested fee schedule for application in Ohio for consideration by the Veterans Administration, and that an advisory committee be established which could work closely with officials of the Veterans Administration in charge of its activities in Ohio.

General Hawley informed Dr. Paryzek that it is the hope of the Veterans Administration that all veterans requiring out-patient care will be able to obtain such care from their own physicians and that eventually agreements can be worked out with civilian hospitals to provide hospital services for many eligible veterans so veterans can be hospitalized locally and receive attention when hospitalized from local physicians.

CONFERENCE WITH OHIO OFFICIAL

Also, reports were submitted to the committee on conferences between Mr. Ralph H. Stone, deputy administrator in charge of the Veterans Administration Branch Office, Columbus, and Executive Secretary Nelson and Assistant Executive Secretary Saville. The Branch Office will direct all Veterans Administration activities for the states of Ohio, Michigan, and Kentucky, being one of the 13 offices established by the agency under the decentralization policy of General Omar Bradley, administrator of the Veterans Administration.

Information on programs which have been worked out, or which are under consideration, between the Veterans Admnistration and the medical profession of the states of Michigan, California, Kansas, and New Jersey was reviewed.

PROGRESS IN OTHER STATES

In Michigan, California, and New Jersey it is planned to utilize the services and facilities of the prepaid medical care plan of the state medical society in handling administrative details involved in a program to provide medical care to eligible disabled veterans. For example in Michigan, Michigan Medical Service will serve as an agent for the physicians and the Veterans Administration. Members of the Michigan State Medical Society who indicate they are willing to render services to veterans in authorized cases at fees comparable to those in the Minimum Fee Schedule of the Michigan State Medical Society will send their bills to Michigan Medical Service. That agency will pay the physician and in turn will bill the Veterans Administration monthly for the total amount of fees paid. Through this method, physicians will deal directly with their own medical care plan on matters pertaining to veterans. This plan started operation on February 8.

Under the Kansas plan, the state medical society plans to submit a list of physicians desiring to do work for the Veterans Administration in accordance with a state-wide fee schedule agreed upon by the society and the Veterans Administration. The physician will submit his fee bill to the Veterans Administration but the medical society will establish boards of physicians to act in an advisory capacity to Veterans Administration offices in Kansas, and to assist those offices in checking claims, fee bills, adjudication of disputes, etc.

The plans proposed by California and New Jersey are comparable in general to the Michigan program.

NEED DOCTORS FOR EXAMINATIONS

The situation in Ohio was reviewed. It was found that the Veterans Administration Regional Offices at Cleveland and Dayton as well as the local district offices are in need of physicians to perform physical examinations in the cases of veterans who have applied or are applying for disability compensation. It was reported that both General Hawley and Mr. Stone are anxious

to have these examinations made by physicians who are practicing in the home towns of veterans and who would be paid on a fee-for-service basis, providing the State Association would furnish the names of physicians willing to make the examinations.

COMMITTEE ACTS

After a general discussion of the various problems entailed in setting up a satisfactory program in Ohio, the committee took the following actions:

1. Offered to the Veterans Administration the cooperation of the Ohio State Medical Association in obtaining the names of physicians in private practice who are competent and willing to make physical examinations of claimants for disability compensation in their own offices on a fee-for-service basis. It authorized the mailing of a bulletin to all County Medical Society Presidents and Secretaries requesting the society to send to the Columbus office of the Association the names of such physicians so such lists can be turned over to the Veterans Administration's Ohio offices and the system of having the physical examinations made in the home communities of the veterans inaugurated at an early date.

2. Instructed the Executive Secretary to communicate with the officials of Ohio Medical Indemnity, Inc., expressing the hope of the committee that Ohio Medical Indemnity, Inc., might be able to function in Ohio as Michigan Medical Service is serving in Michigan on matters relating to the medical care of veterans and requesting Ohio Medical Indemnity, Inc., to investigate the question, and inform the committee of its views at an early date.

3. Recommended that the possibilities be explored of having the Columbus office of the Ohio State Medical Association serve as an agency between the Veterans Administration and physicians in a capacity similar to that of Michigan Medical Service, in event Ohio Medical Indemnity, Inc., can not undertake this activity.

4. Requested that more information be obtained regarding the Kansas and New Jersey proposals.

5. Authorized the chairman to appoint a subcommittee to consider the question of developing a state-wide fee schedule for presentation to the Veterans Administration and to report its findings at the next meeting of the committee.

6. Endorsed the action of The Council in asking each County Medical Society to appoint a local Committee on the Medical Care of Veterans to serve as a local sub-committee for the State Association committee and to act in an advisory capacity to the state committee.

It is anticipated that further action will be taken on the matters discussed at a meeting of the committee on March 3, so a progress report can be submitted to The Council on March 10.

V.A. NEEDS DOCTORS FOR RATING BOARD POSITIONS

The Veterans Administration is urgently in need of physicians for rating board work, either on a full-time or part-time basis. As a member of a rating board, a physician, on the basis of the available evidence, advises the board as to the nature and extent of disability in claims for pension, and assumes responsibility jointly with the other members as to entitlement under existing laws and regulations. Physicians interested in work of this nature should contact the nearest office of the Veterans Administration for details. The basic salary is $4300.00 per annum, with additional compensation for overtime.

COMING MEETINGS

Ohio State Medical Association, Columbus, May 7-9.

American Medical Association, San Francisco, July 1-5.

American Association of Pathologists and Bacteriologists, Cleveland, March 8-9.

American Association for Thoracic Surgery, Detroit, May 29-31.

American Association of Anatomists, Cleveland, April 4-6.

American Association for the Study of Goiter, Chicago, June 20-22.

American College of Physicians, Philadelphia, May 13-17.

American Dietetic Association, Cincinnati, Oct. 14-18.

American Physiological Society, Atlantic City, March 11-15.

American Roentgen Ray Society, Cincinnati, Sept. 17-20.

American Society for Experimental Pathology, Atlantic City, March 11-15.

American Society for Pharmacology and Experimental Therapeutics, Atlantic City, March 11-15.

American Surgical Association, Hot Springs, Va., April 2-4.

Annual Postgraduate Assembly, Mahoning County Medical Society, Youngstown, April 17.

Chicago Medical Society Annual Clinical Conference, Chicago, March 5-8.

Federation of American Societies for Experimental Biology, Atlantic City, March 11-15.

Northern Tri-State Medical Association, South Bend, Indiana, April 9.

Post-Collegiate Assembly, Ohio State University College of Medicine, Columbus, March 27.

Educational Provisions of G.I. Bill Applying To Veteran Physicians Are Clarified in Recent Rulings

IN a recent ruling, the Administrator of Veterans' Affairs clarified one question relating to the educational provisions of the G.I. Bill of Rights, namely, that otherwise qualified physician veterans pursuing training in connection with residencies or fellowships are eligible for subsistence benefits under the G.I. Bill and approved hospitals are eligible to apply for their tuition.

This ruling applies to all acceptable residency hospitals, whether or not they are affiliated with a medical school. However, no hospital can participate unless it is approved by the appropriate state agency, and veterans will receive no subsistence allowance while serving as residents in a hospital not so approved. In Ohio, the approving agency is the State Department of Education, State Office Building, Columbus.

AMOUNTS AND ELIGIBILITY

Eligible veterans will receive a monthly subsistence check for $65 if without dependents, or $90 if with a dependent or dependents. These payments will not be made during terminal leave. Tuition and subsistence benefits will not be charged against the veteran's bonus, should one be voted later by Congress.

Those eligible are honorably discharged physician veterans of World War II, and the benefits will extend for a period of time equal to one year plus the duration of their active duty since September 16, 1940, and prior to the termination of the war. Time spent on active duty in the A.S.T. or Navy V-12 program is not included. Total benefits are not to exceed a period of four years.

It is no longer necessary for the veteran to show that his training was interrupted by the war. Also, age when entering active duty is no longer a factor. The period of training must be commenced within four years of discharge, or the termination of the war, whichever is the later, and completed within the nine year limitation.

WHERE TO FILE FORM

To establish his eligibility, the veteran must file an application on Veterans' Administration Rehabilitation form 1950 at the regional office of the Veterans' Administration. In Ohio, this form may be filed at the regional office at Brecksville or the one at Dayton.

A certified or photostatic copy of discharge should accompany the application.

From the regional office, the veteran should receive a Certificate of Eligibility and Entitlement, VA form 1953, which indicates the duration of the training to which he is entitled. This certificate must be endorsed by the approved hospital and forwarded to the regional office of the Veterans' Administration. Benefits can not be paid until this process has been completed.

BE SURE AGENCY IS APPROVED

It is important for the veteran to make certain that the hospital has been approved by the state approving agency. It is to his interest also to make certain that an approved training institution is selected, lest the work proves later to be useless for such special purposes as certification by one of the American Boards in the specialties.

An eligible physician veteran may embark on his educational program during his period of terminal leave, and tuition payments will be made to the hospital, but subsistence payments will not be paid to the veteran until his discharge.

PAYMENTS TO INSTITUTIONS

Special provisions are made for payments to educational institutions having no established tuition fee. These apply to approved residency hospitals, which rarely have an established fee. Four alternatives are available:

1. The hospital may request no payments. This does not affect subsistence payment to the veteran.
2. The hospital may have a regularly established tuition fee, which it may request from the regional office of the VA. This would usually be limited to university or medical school hospitals.
3. Hospitals may avail themselves of regulations in VA instruction No. 6, Title II, Public Law 346, which provides that any approved educational institution that has no established tuition fee, or whose fee is considered inadequate, may charge for each veteran enrolled in a full time course, as much as $15 a month, $45 per quarter, or $60 per semester. Residency hospitals selecting this basis of compensation would be paid $15 a month or $180 for a course of 52 weeks.
4. A hospital that has no established tuition or considers its established fees to be inadequate may be paid fair and reasonable compensation not exceeding the estimated cost of teaching personnel and supplies for instruction.

REGARDING SHORT REFRESHER COURSES

Institutions providing review and refresher courses of less than 30 weeks and having regularly established fees, must be approved by the state approving agency and must arrange for tuition payments with the regional offices of the Veterans' Administration.

The fee can be charged, provided that the cost is not in excess of the rate of $500 for a full-time course for an ordinary school year. If the customary charges are in excess of this

rate, the VA must find that the cost is reasonable and fair. For these refresher courses there will be charged against the veteran's time period of eligibility the proportion of an ordinary school year which the cost of the course bears to $500. That is, if he elects a two months course for which $250 is paid, he will have half an ordinary school year charged against his right for further education.

This information is based on a statement by the Subcommittee on Veterans' Affairs of the A.M.A. Committee on Postwar Medical Service and the provisions of the amended Servicemen's Readjustment Act are included.

New Rules on Surplus Goods Sales to Public Health Claimants

Instructions to eligible public health claimants for purchasing surplus property at 40 per cent discount are available from the U. S. Public Health Service.

The Federal Security Agency, through the U. S. Public Health Service, a constituent unit, serves in an advisory capacity to the War Assets Corporation in the distribution of surplus property. The new instructions replace an interim procedure which expired February 16.

A 40 per cent discount from "fair value", will be granted eligible public health claimants. "Fair value" is defined as the lowest price prevailing at any trade level at the time of transaction.

Included among eligible claimant groups are state, county, and local official public health agencies, such as health and sanitation departments, water works, sewage systems, garbage, and disposal plants; hospitals operated by non-Federal governmental agencies, non-profit hospitals, clinics, and public health research organizations; schools of nursing, medicine, dentistry, public health, and pharmacy; and certain miscellaneous non-profit groups organized primarily to promote the public health.

Application must be approved by a Public Health Service representative. Applicants in doubt of their eligibility should consult the nearest Public Health Service Representative, Office of Surplus Property Utilization. The office serving Ohio is located at 704 Race Street, Cincinnati 2.

Consumer goods offered for sale comprise a wide range of products normally handled in everyday retail trade. They include such things as clothing, textiles, lunchroom equipment, furniture, office equipment, automobiles, trucks, tires, hardware, surgical and medical equipment, vocational training equipment, agricultural and construction machinery, farm supplies and tools, photographic equipment, and the like.

Capital goods offered include such items as industrial plant equipment, raw materials other than food, partly finished materials, aircraft machinery, machine tools, electronics, metals, ores, fibres, chemicals, oil and coal products, transportation equipment.

To buy consumers goods, claimants should request notification of sales offerings suitable to their needs from the nearest regional WAC office for consumer goods, at which U. S. Public Health Service representatives are stationed (Cincinnati).

To purchase capital goods, claimants may obtain lists of standardized items from the nearest of the 31 regional WAC offices handling such items. Information regarding availability of unlisted capital goods may be obtained by specifically describing the items needed. The regional office serving Ohio is located at Newman-Stern Bldg., Cleveland.

Inquiries concerning availability of surplus foods should be directed to the United States Department of Agriculture, Production and Marketing Administration, Attention: Surplus Property, Washington 25, D. C.

Copies of instructions which give full information as to applications and orders may be obtained from the Office of Surplus Property Utilization, U. S. Public Health Service, Railroad Retirement Building, Washington 25, D. C., and from the USPHS representative in the WAC regional consumer goods office (Cincinnati).

Physician veterans of World War II are also permitted to purchase surplus war equipment. Under present rulings they have third priority to this privilege, but are not entitled to the 40 per cent discount.

Exams for U.S.P.H.S. Jobs Scheduled

Examinations for permanent appointments of medical officers in the Regular Corps of the United States Public Health Service will begin on April 4 at various convenient localities throughout the country. Examinations are for appointments to fill vacancies of Assistant Surgeon (First Lieutenant) and Senior Assistant Surgeon (Captain). Entrance pay for Assistant Surgeon with dependents is $3,411 a year, and for Senior Assistant Surgeon with dependents is $3,991 a year. Promotions are at regular intervals up to and including the grade of Medical Director which corresponds to full Colonel at $7,951 a year. Retirement pay at 64 is $4,500 a year. Full medical care including disability retirement at three-fourth pay is provided as well as 30 days' annual leave with pay.

Written examinations will be held May 14, 15, and 16. Oral examinations will be held at the Marine Hospital, Cleveland, at 9 A.M., May 3, for applicants in this area.

Application forms and additional information may be obtained by writing the Surgeon General, U. S. Public Health Service, Washington 25, D. C.

VETERANS' INQUIRY DEPARTMENT

Ohio Openings and Locations Sought by Returning Medical Officers; Opportunities Available Listed

THE purpose of this department is to provide space without cost to Ohio veteran physicians for the publication of inquiries they may wish to make concerning an assistantship or residency, a partnership or space in an office, locations and purchase of a practice, purchase of equipment, etc.

The new feature also offers an opportunity for physicians who desire to dispose of their practice or institutions and agencies needing staff physicians to publicize this information for the benefit of service men.

The feature will appear monthly as long as there seems to be a need for it. The regulations governing it are: (1) The veteran submitting the inquiry must be an Ohio physician, i.e., one who was in practice in Ohio when he entered the service or was a native of Ohio but still in training when he entered in the service. (2) Inquiries should not exceed 35 words. (3) Copy must be submitted by the 20th day of the month preceding date of publication. (4) Unless otherwise specified, each inquiry will be carried in two consecutive issues of *The Journal* but no oftener. (5) *The Journal* reserves the right to reject or edit copy submitted; also, to eliminate the new department when and if conditions warrant. (6) Inquiries should be accompanied by full name, forwarding address and identifying data.

OPPORTUNITIES SOUGHT

PEDIATRICIAN: Navy medical officer, aged 33, graduate of Ohio State University College of Medicine, trained in pediatrics, interested in pediatrics practice—preferably with group clinic. V.I.D. No. 1, care of Ohio State Medical Journal.

GENERAL SURGERY: Discharged Army medical officer, age 35, graduate of Northwestern University Medical School, surgical residency in approved Ohio hospital, seeking general surgical practice in Ohio or associateship or assistantship with man in practice. V.I.D. No. 2, care of Ohio State Medical Journal.

OTOLARYNGOLOGY TRAINING: Training in Otolaryngology through residency or assistantship sought by Army medical officer to be separated from service soon; age 32; graduate of Ohio State University College of Medicine. V.I.D. No. 3, care of Ohio State Medical Journal.

OBSTETRICAL TRAINING: Discharged medical officer desires assistantship or short residency in obstetrics and gynecological surgery or general surgery for period of month, six weeks or two months; age 48; graduate of St. Louis University School of Medicine. V.I.D. No. 4, care of Ohio State Medical Journal.

SURGICAL ASSISTANTSHIP: Wanted by veteran, age 33; six years surgical training including year of thoracic surgery; four years of Army surgery in states and overseas. Available after January 2. Ohio license. V.I.D. No. 5, care of Ohio State Medical Journal.

SURGICAL PRACTICE: Discharged medical officer, age 32, graduate of Ohio State University College of Medicine and residency in surgery, University Hospitals, Minneapolis, desires surgical practice. V.I.D., No. 6, care of Ohio State Medical Journal.

EQUIPMENT NEEDED: Returning medical officer desires to purchase an Ear, Nose and Throat Unit, new, or second hand if in good condition. V.I.D., No. 7, care of Ohio State Medical Journal.

CAN YOU PROVIDE ANY LEADS WHICH WOULD HELP THESE PHYSICIANS?

It is difficult for the Columbus office to supply the answers to inquiries which are being received from some returning medical officers seeking locations for practice.

Some of the answers can be supplied only by physicians in various parts of the state. Therefore, the Columbus office solicits the help of each member.

Following are some of the inquiries for which data are needed. If you have any suggestions, write the Columbus office:

"Where can I become an associate with an eye, ear, nose and throat specialist?"

"Give me the name of a city needing the part-time services of an anesthetist."

"Which cities could use a specialist in dermatology?"

"Where is there an opening for a colored physician?"

"I would like to become associated with a group. Have you any suggestions?"

"Send a list of cities which need a specialist in urology."

"Do you know of a surgeon who desires an assistant?"

"Suggest a city where I could engage in part-time industrial work."

PEDIATRICS OR GENERAL PRACTICE: Practice in pediatrics or general practice sought by discharged Army medical officer, 45 years of age, diplomate of American Board of Pediatrics. Willing to invest. Available immediately. V. I. D. No. 8, care of Ohio State Medical Journal.

LOCUM TENENS OR ASSISTANTSHIP: Wanted for eight months by discharged flight surgeon who will begin ENT postgraduate course Sept. 1; O.S.U. '37; aged 32; experienced in industrial surgical practice. V.I.D. No. 9, care of Ohio State Medical Journal.

SURGICAL RESIDENCY WANTED: By returning medical officer, age 46, with 15 years general practice and surgery; three years assistantship to general surgeon; 20

months in general surgery in Army overseas. Available after January 1. V.I.D. No. 10, care of Ohio State Medical Journal.

PRACTICE WANTED: Veteran will buy practice of retiring or deceased physician, small city preferred. Ten years' practice before entering service. V.I.D. No. 11, care of Ohio State Medical Journal.

INDUSTRIAL OR INSURANCE POSITION WANTED: By discharged Army medical officer. Ten years in general practice. Over three years in service, mostly spent as administrative head of installation doing large number of physical examinations. Age 44. V.I.D. No. 12, care of Ohio State Medical Journal.

OPHTHALMOLOGY TRAINING SOUGHT: Training in ophthalmology through residency or assistantship wanted by discharged Army medical officer; ten months' eye work in Army; capable refractionist. Age 34. Graduate of Ohio State University College of Medicine. V.I.D. No. 13, care of Ohio State Medical Journal.

TRAINING IN OTOLARYNGOLOGY: Discharged Naval flight surgeon, with 62 months of military service, age 41, graduate of Ohio State University, desires post-graduate training in otolaryngology and refraction by means of residency or assistantship. V.I.D. No. 14, care of Ohio State Medical Journal.

ASSOCIATION SOUGHT: Discharged Navy medical officer, age 33, thorough training in internal medicine, especially cardiology, graduate of University of Cincinnati, desires association with established internist or group clinic. Will locate in small town in need of internist. Member of Cincinnati Academy of Medicine. V.I.D. No. 15, care of Ohio State Medical Journal.

INTERNIST SEEKS OPENING: Internist, with two and one-half years clinical training, completing American Board of Internal Medicine examinations, age 33, licensed in Ohio, desires association with group or well-established internist. Available after April 1, 1946. V.I.D. No. 16, care of Ohio State Medical Journal.

WANTS SURGICAL RESIDENCY: Veteran medical officer, age 36, with year's internship, year of general residency, two years of general practice and 57 months service in Army as battalion surgeon and 25 months with orthopedic section of general hospital, desires approved residency in general surgery. V.I.D. No. 17, care of Ohio State Medical Journal.

ASSOCIATE PRACTICE SOUGHT: Internist, age 31, graduate of University of Cincinnati College of Medicine, 1938, four years hospital training, including one year cardiac fellowship, eligible for certification by American board, desires association with internist or group. Available immediately. V.I.D. No. 18, care of Ohio State Medical Journal.

PRACTICE WANTED: Obstetrician and gynecologist, discharged medical officer, age 38, desires obstetrical and gynecological practice or association; eligible for American board. V.I.D. No. 19, care of Ohio State Medical Journal.

RESIDENCY DESIRED: A gynecological or surgical residency wanted by returning medical officer, age 42, with three and one-half years hospital training and 10 years general practice; available in March. V.I.D. No. 20 care of Ohio State Medical Journal.

OPPORTUNITIES OFFERED

GENERAL PRACTICE: Opportunity for general practice in town of 1,000 in Northwestern Ohio. Only one other physician. Home and office space available. One of Ohio's best agricultural areas and good marketing section. Write W. L. G., care of Ohio State Medical Journal.

STUDENT HEALTH SERVICE: Opening at Ohio University, Athens, in Student Health Service on trial basis, if desirable, with view to permanent arrangement later. Student enrollment about 2,000. Well-organized service, with small hospital and X-ray equipment. Young medical graduate preferred, but will consider others. Write or see Dr. E. H. Hudson, director, Student Health Service, Ohio University, Athens; telephone 24532.

GENERAL PRACTICE AVAILABLE: Physician wishing to retire wants to dispose of practice to returning veteran. Located in Wilmington, Clinton County, excellent farming community; good roads. Equipment includes modern furniture, large supply of drugs, supplies and instruments and library. Office rent reasonable and equipment and practice priced to sell immediately. R. H. Vance, M.D., 114 East Locust Street, Wilmington.

PLACE FOR GENERAL PRACTITIONER: Civic Association of Alger, Hardin County, population of 857, sponsoring project to secure physician for area. Good farming district and modern improvements. Good opportunity for energetic doctor. Communicate with Mr. Glenn Hanson, president, Alger Civic Association.

INDUSTRIAL POSITION: Desirable position on medical staff of large rubber company; good salary. F.T.R., care of Ohio State Medical Journal.

INDUSTRIAL COMMISSION: Openings available in Medical Section, Ohio Industrial Commission. Consult Dr. Robert André, chief supervisor, Medical Section, State Office Bldg., Columbus.

PRACTICE AND OFFICE FOR SALE: Practice in community of 2,000, unopposed; modern six-room recently constructed brick office building for sale or rent. Combined industrial and rural practice. H.B.K., care of Ohio State Medical Journal.

PARTNERSHIP: Good location for young M.D. Will consider partnership, nothing to sell. Five-room apartment above office available for living quarters. Contact Dr. A. B. Martin, Blanchester, Ohio.

EMPLOYMENT OPPORTUNITIES: For physicians, good salary, institution for mentally deficient. Indiana license necessary. Write or wire Fort Wayne School, Fort Wayne 1, Indiana.

ASSISTANT DIVISION CHIEF: Position for physician as Assistant Chief, Division of Child Hygiene, Ohio Department of Health, available. Salary $4,400 to $4,800. Must be graduate of approved medical school, one year's internship and at least one year's graduate training, plus one year of training or experience in clinical pediatrics. Experience in maternal and child health desirable. Must be licensed in Ohio or eligible for licensure. Apply, Chief of Division of Child Hygiene, Ohio Department of Health, State Departments Building, Columbus 15.

STATE HOSPITAL STAFF OPENINGS: Staff physicians for various institutions serving the mentally ill, mentally defective and epileptic needed. Physicians who have had some psychiatric training or experience preferred but can offer positions to doctors who may be interested in becoming acquainted with the specialty. Two positions of special importance now open are: Superintendency, Youngstown Receiving Hospital (especially attractive for young physician with residency in psychiatry) and Clinical Directorship, Gallipolis State Institute (fine opportunity for man who has had neuropsychiatric training to become acquainted with those neurological conditions that cause epilepsy in addition to a chance to be a specialist in the field of true epilepsy). Consult Dr. Frank F. Tallman, Ohio Commissioner of Mental Hygiene, State Departments Building, Columbus 15.

PUBLIC HEALTH OFFICERS NEEDED: Several counties in Ohio in need of full-time health commissioners. Those with training and experience, or interested in public health work, may obtain complete details from Dr. Roger Heering, Ohio Director of Health, State Departments Building, Columbus 15.

AREAS NEEDING PHYSICIANS: A list of Ohio areas badly in need of physicians, primarily for general practice—communities which were not the residence of any medical officer prior to the war—will be furnished on inquiry by the Headquarters Office, Ohio State Medical Association, Columbus.

PRACTICE FOR SALE: Active practice in county seat, Northwestern Ohio, for sale. Average of 100 obstetrical cases a year. Most physicians in upper age group. Railroad and insurance appointments available. Introduction and help for limited time offered. Equipment includes X-ray, diathermy, modern furniture, complete tonsillectomy instruments, large supply of drugs and supplies. Complete records of patients on file. No real estate for sale. Nominal rent. Hospitals nearby. Thriving industries and fine agriculture community, with paved roads. Estimated price, without complete inventory, $4,000 to $5,000. Box X, Ohio State Medical Journal.

PRACTICE FOR SALE: Active practice in a community of 3,000, North Central Ohio. Large amount of industrial work in addition to regular practice. Equipment includes new X-ray, diathermy, modern furniture, drugs and supplies. No real estate for sale. Moderate rent. Estimated price $7,500, cash or terms. Will introduce for a short time. Write R.J.S., care of Ohio State Medical Journal.

TUBERCULOSIS HOSPITAL OPENING: Resident physician needed in this institution doing intensive collapse therapy, including surgery. Good opening for man who desires to enter this field of medicine. District Tuberculosis Hospital, Lima; H. H. Brueckner, M.D., superintendent.

VETERANS ADMINISTRATION: Openings for physicians as members of rating boards for either full time or part time duty. Basic salary $4300.00 per annum, with additional compensation for overtime. Contact nearest V.A. office for particulars.

Annual Post-Collegiate Assembly, Ohio State University, College of Medicine, Resumed; Scheduled for March 27

THE College of Medicine of Ohio State University is resuming its Annual Post-Collegiate Assembly, with a one-day refresher course, Wednesday, March 27, at Campbell Hall, on the University Campus, Columbus. All doctors of medicine are cordially invited to attend.

Dr. Charles A. Doan, Dean of the College, will outline the future program for training physicians and adjunct workers, and plans for graduate service and research anticipated in connection with the $5,000,000 expansion program authorized by the Legislature last year. Seven recently-appointed faculty members will present the latest approach to several current medical problems.

A special feature of the program will be an address on "The Effects of the Atomic Bomb at Hiroshima", by Lt. Col. Hymer L. Friedell, M.C., U.S. Army, executive officer, Manhattan Project, Medical Research Section. The address will be accompanied by an official color movie with sound.

The complete program follows:

Morning Session

Registration—9:00 A. M.—9:50 A. M.

Russel G. Means, M.D., Chairman, presiding.

10:00 Howard L. Bevis, L.L.D., President, Ohio State University. The Program For the Medical College in the University Planning.
10:10 Warren E. Wheeler, M.D., associate professor of pediatrics. Pediatrics Problems in the Post War Period.
10:40 Shelby G. Gamble, M.D., assistant professor of medicine, director of physical medicine. Physical Medicine, Its Growing Importance in Modern Medical Practice.
11:10 Recess.
11:15 Arthur M. Culler, M.D., associate professor of ophthalmology. Progress in Ophthalmologic Practice and Research.
11:25 Herman A. Hoster, M.D., associate professor, associate director, Division Cancer Research, Department of Medical Research. The Present Status of Cancer Research on the Campus at Ohio State University.
12:00 Noon—Luncheon.

Afternoon Session

1:30 Presiding, Rollo C. Baker, Ph.D., Secretary, College of Medicine. The Background of Our Medical Center.
1:40 John B. Fullen, Executive Secretary of The Ohio State University Alumni Association and Director of the University Development Fund. The Place of the Medical Alumni in University Planning.
1:50 Charles A. Doan, M.D., Dean of the College of Medicine, Director University Hospital, Director of Medical Research. The Current Personnel and Physical Expansion of the College of Medicine: Its Teaching and Research Programs.
2:30 Wm. G. Myers, M.D., Fellow of the Julius F. Stone Bio-Physics Medical Research Foundation. Some Applications of Atomic Energy to Diagnosis and Therapy.
2:55 Recess.
3:00 Allen C. Barnes, M.D., associate professor of obstetrics and gynecology. The Future of Obstetric and Gynecologic Practice.
3:30 Robert M. Zollinger, M.D., professor of surgery. Current Problems in General Surgery and Their Solution.
4:05 Recess.
4:15 Guest Lecturer. Lt., Col. Hymer L. Friedell, M.D., Ph.D.; M.C., U.S. Army; executive Officer, Manhattan Project, Medical Research Section also for Medical Observations at Hiroshima. The Effects of the Atomic Bomb at Hiroshima. Illustrated by an official color movie with sound.
6:30 Fraternity Banquet—Class reunions.

The program was arranged by the Post-College Assembly Committee, composed of Dr. Russel G. Means, chairman; Dr. Jonathan Forman, Dr. Verne A. Dodd, Dr. N. Paul Hudson, Dr. Bruce K. Wiseman, and Dr. C. C. Sherburne.

Officers of the College of Medicine Alumni Association are: Dr. Nial L. Burrell, Springfield, president; Dr. Robert C. Austin, Dayton, first vice-president; Dr. Wm. L. Skipp, Youngstown, second vice-president; Dr. Forman, Columbus, editor and historian; Dr. Means, Columbus, secretary, and John B. Fullen, executive secretary, Ohio State University Alumni Association.

Gastroenterology Prize Contest

The National Gastroenterological Association has announced the establishment of an Annual Cash Prize Award of $100 and a Certificate of Merit for the best unpublished contribution on gastroenterology or allied subjects. Certificates will also be awarded those physicians whose contributions are deemed worthy.

Contestants residing in the United States must be members of the American Medical Association. The winning contribution will be selected by a board of impartial judges and the award is to be made at the Annual Convention Banquet of the National Gastroenterological Association to be held at the Hotel Pennsylvania in New York City on June 20, 1946.

All entries for the 1946 prize should be limited to 5,000 words, be typewritten in English, prepared in manuscript form, submitted in five copies, accompanied by an entry letter, and must be received not later than May 1, 1946. Entries should be addressed to the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

Ohio Physicians Released from Active Military Service During Past 30 Days, Based on Reports to O.S.M.A.

DURING the past 30 days, the names of 271 additional Ohio physicians have been reported to *The Journal* and the Ohio State Medical Association as having been released from active military service.

Up to February 21, a total of 1,078 Ohio medical officers have been released from military service or have started terminal leave since V-E Day, according to reports received by the State Association.

There may be other Ohio physicians who have terminated their military duties. If so, their names have not as yet been reported to the State Association. **It is hoped they, or their relatives or acquaintances, will send in this information at once, so their names can be included in lists which will be published in future issues of The Journal. County Society officers are urged especially to send in the names of returning medical officers, so State Association records and mailing lists can be adjusted.**

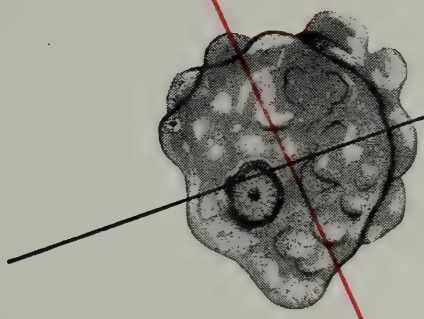
Medical officers are again reminded that the Columbus office of the State Association is prepared to furnish them with leads as to opportunities for postgraduate education and possibilities for practice.

The following tabulation lists the names of Oho medical officers reported as having been released from service during the past month. The city in which the physician resided or practiced when he entered the service is given in most instances. However, if the physician, after separation, changed location and this information is known, the place of relocation also is indicated. The rank shown is based on latest information on file with the State Association and, of course, may not be up to date in some instances:

Name	City	Rank
Alpers, Nathan	Cleveland	Capt., A.U.S.
Adolph, Paul E.	Philadelphia, Pa. (formerly of Bellevue)	Lt. Col., A.U.S.
Allison, Robert T.	Akron	Lt. Col., A.U.S.
Ameter, Russell K.	Bryan	Major, A.U.S.
Anagnost, Basil D.	Toledo	Capt., A.U.S.
Artman, Edwin H.	Chillicothe	1st Lt., A.U.S.
Bane, Russell C.	Chillicothe	Major, A.U.S.
Barkman, Floyd J.	Cincinnati	Comdr., U.S.N.R.
Barnhiser, Von B.	Camden	Lt. Col., A.U.S.
Baumgartner, Myron R.	Dalton (formerly of Bolivar)	Capt., A.U.S.
Bayha, Carl H.	Toledo	Comdr., U.S.N.R.
Beekley, Henry C.	Cincinnati	Capt., A.U.S.
Bennett, Paul E.	Cincinnati	1st Lt., A.U.S.
Berger, Irving L.	Cleveland	Lt. Col., A.U.S.
Bershon, Albert L.	Toledo	Lt. Col., A.U.S.
Beshera, Edmund	Massillon	Major, A.U.S.
Beyer, Millard C.	Akron	Major, A.U.S.
Blaugrund, Charles	Garfield Heights	Major, A.U.S.
Bogue, Charles A.	Warren	Capt., A.U.S.
Bolin, Joseph B.	Norwood	Comdr., U.S.N.R.
Bone, R. M.	Cleveland	Lt., U.S.N.R.
Borreson, Albert	Greenfield	Lt. Col., A.U.S.
Botsch, Bernard	Toledo	Lt., U.S.N.R.
Bowman, Brack M.	Youngstown	Lt. Col., A.U.S.
Bowsher, Robert E.	Toledo	Major, A.U.S.
Brandeberry, N. A.	Springfield	Major, A.U.S.
Brandmiller, B. M.	Youngstown	Capt., A.U.S.
Brief, Bernard J.	Columbus	Capt., A.U.S.
Briola, P. F.	Cleveland	Lt. Col., A.U.S.
Brogden, William E.	Canton	Lt. Col., A.U.S.
Brown, John Q.	Columbus	Capt., A.U.S.
Burgner, E. W.	Akron	Major, A.U.S.
Burkons, Harold F.	Cleveland	Major, A.U.S.
Castle, G. H.	Cincinnati	Comdr., U.S.N.R.
Christman, H. E.	Lakewood	Lt. Comdr., U.S.N.R.
Coleman, Marion W.	Dayton	Capt., U.S.N.R.
Conn, Harry G.	Toledo	Major, A.U.S.
Coulson, A. A.	McConnelsville (formerly of Malta)	Lt. Comdr., U.S.N.R.
Craver, William	Columbus	Lt., U.S.N.R.
Cress, O. E.	Van Wert	Capt., A.U.S.
Crone, Paul C.	Cleveland	Major, A.U.S.
Cronin, John F.	Cincinnati	Lt. Col., A.U.S.
Cukerbaum, Alfred R.	Youngstown	Comdr., U.S.N.R.
Curtzwiler, Francis C.	Toledo	Lt. Col., A.U.S.
Czarnecki, John	Toledo	Lt. Comdr., U.S.N.R.
Damstra, Eugene F.	Dayton	Lt. Col., A.U.S.
Deger, Robert J.	Dayton	Major, A.U.S.
Dickson, Ross D.	Topeka, Kansas (formerly of Gibsonburg)	Capt., A.U.S.
Disbro, P. P.	Cleveland	Lt. Comdr., U.S.N.R.
Doeing, Carl T.	Springfield	Lt. Col., A.U.S.
Dornheggen, John H.	Cincinnati	Major, A.U.S.
Dowell, Charles H.	Carrollton	Capt., A.U.S.
Eckel, Harold W.	Cincinnati	Capt., A.U.S.
Edwards, Thomas L.	Ann Arbor, Michigan (formerly of Van Wert)	Major, A.U.S.
Eichner, Eduard	Cleveland	Comdr., U.S.N.R.
Ellis, Samuel C.	Xenia	Col., A.U.S.
Elsey, Edward C.	Cincinnati	Lt. Col., A.U.S.
Engel, Walter G.	Cincinnati	Major, A.U.S.
Epler, Deane C.	Bozeman, Montana (formerly of Columbus)	Major, A.U.S.
Evans, William H.	Youngstown	Comdr., U.S.N.R.
Fasoldt, L. O.	Glendale	Capt., A.U.S.
Felker, Crawford L.	Toledo	Major, A.U.S.
Fisher, Abe A.	Canton	Major, A.U.S.
Fisher, James L.	Youngstown	Comdr., U.S.N.R.
Flook, Samuel E.	Dayton	Lt., U.S.N.R.
Floridis, Gregory G.	Dayton	Lt. Col., A.U.S.
Foley, Norman K.	Toledo	Lt. Col., A.U.S.
Folin, J. J.	Cleveland (formerly of Barberton)	Capt., A.U.S.
Foy, Paul E.	Troy	Major, A.U.S.
Franke, William J.	Akron	Capt., A.U.S.
Franz, Lyle C.	Cincinnati	Capt., A.U.S.
Freiden, Joseph N.	Norwood	Capt., A.U.S.
Friedman, Leo S.	Cincinnati	Lt. Col., A.U.S.
Gardner, George E.	Lancaster	Lt. Comdr., U.S.N.R.
Garrett, William M.	Frankfort	Capt., A.U.S.
Garvin, Edward R.	Toledo	Comdr., U.S.N.R.
Gaspari, Emidio L.	Toledo	Comdr., U.S.N.R.
Geoghegan, T. W.	Fostoria	Lt. Comdr., U.S.N.R.
Gitman, William H.	Dayton	Capt., A.U.S.
Gledhill, Joseph M.	Warren	Capt., A.U.S.
Goldstein, Marvin B.	Youngstown	Comdr., U.S.N.R.
Goler, Harold K.	Cleveland	Lt. Col., A.U.S.
Gray, James	Lakewood	Comdr., U.S.N.R.
Gray, Ralph E.	Lake Jackson, Texas (formerly of Cleveland)	Major, A.U.S.
Greenberger, M. L.	Canton	Capt., A.U.S.
Greenburg, Samuel L.	Steubenville	Major, A.U.S.
Greenlee, A. A.	Dennison	Capt., A.U.S.
Gunn, Herman M.	Ashland	Lt. Col., A.U.S.
Hallaran, William R.	Cleveland	Col., A.U.S.
Hantman, Samuel	Cleveland	Major, A.U.S.
Harkey, James M.	Canton	Capt., A.U.S.
Harper, E. O.	Cleveland	Major, A.U.S.
Harvey, Arch D.	Lebanon	Lt. Col., A.U.S.
Hayman, Joseph M., Jr.	Cleveland	Col., A.U.S.
Hedlund, G. O.	Painesville	Comdr., U.S.N.R.
Henderson, John F.	Akron	Capt., A.U.S.
Hepp, William	Norwood	Capt., A.U.S.
High, Luther W.	Millersburg	Capt., A.U.S.
Hoodin, Abraham	Niles	Capt., A.U.S.
Hosking, Frederick S.	Calumet, Mich. (formerly of Cleveland)	Lt. Comdr., U.S.N.R.
Hudson, Charles L.	Cleveland	Major, A.U.S.
Hunting, William F.	Cincinnati	Lt. Col., A.U.S.
Hurless, L. B.	Dayton	Lt. Comdr., U.S.N.R.
Huth, Paul O.	Cambridge	Comdr., U.S.N.R.
Ingling, Howard H.	Springfield	Capt., A.U.S.
Jackson, Harry D.	Circleville	Col., A.U.S.
Johnson, David M.	Columbus	Comdr., U.S.N.R.
Jones, Paul H.	Stockdale	Col., A.U.S.
Jones, Richard C.	Columbus	Lt. Comdr., U.S.N.R.

(Continued on page 290)

in amebiasis:





symptomatic . . . asymptomatic

Barr[1] states: ". . . it is just as important to treat properly the symptomless 'carrier' of this parasite as to treat the patient suffering from amebic dysentery."

Stitt, Clough and Clough[2] report, "The disease may be symptomless . . . These mild or symptomless cases have been shown to outnumber greatly the cases with clinical dysentery. They constitute the carriers or 'cyst-passers'."

DIODOQUIN (5, 7-diiodo-8-hydroxyquinoline) is safe to use even in suspected cases of amebiasis. Nonirritating, nontoxic—Diodoquin has been found promptly destructive to protozoa in amebiasis and Trichomonas hominis (intestinalis).

DIODOQUIN

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

is the registered trademark of G. D. Searle & Co. Chicago 80, Ill.

1. *Barr, D. P.: Modern Medical Therapy in General Practice, 2:1830, Baltimore, Williams & Wilkins Company, 1940.*
2. *Stitt, E. R.; Clough, P. W., and Clough, M. C.: Practical Bacteriology, Haematology and Animal Parasitology, ed. 9, Philadelphia, P. Blakiston's Son & Co., 1938, pp. 410-412.*

SEARLE *Research in the Service of Medicine*

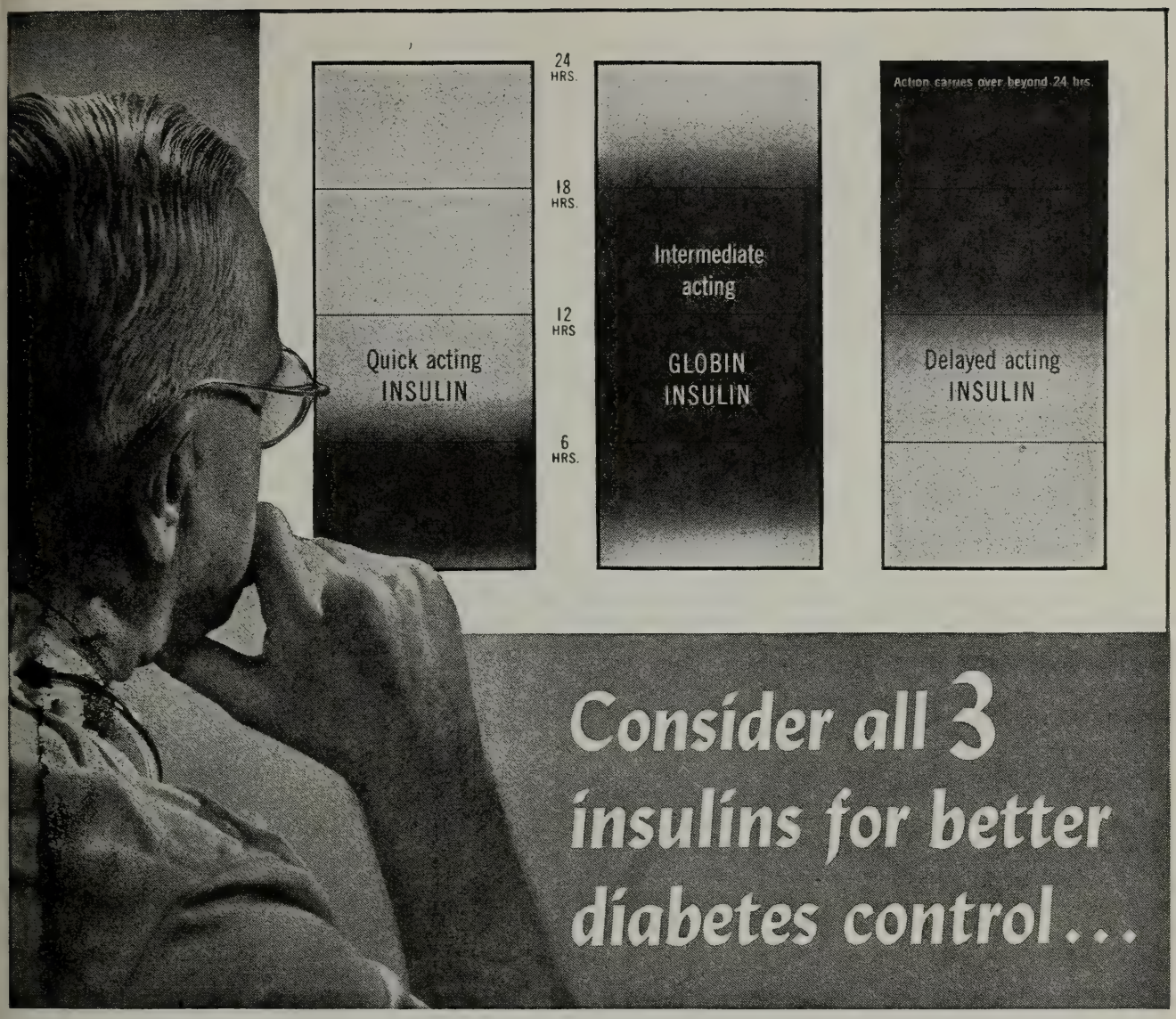
Name	City	Rank
Karwowski, Bernard A.	Toledo	Capt., A.U.S.
Kaufman, Paul M.	Youngstown	Capt., A.U.S.
Keefe, John K.	Cincinnati	Capt., A.U.S.
Keidel, Clifford L.	Cleves	Major, A.U.S.
Keller, William M.	Akron	Capt., A.U.S.
Keogh, Joseph P.	Youngstown	Lt. Comdr., U.S.N.R.
Keyes, Francis G.	Cuyahoga Falls	Capt., A.U.S.
Keys, Harry J.	Columbus	Capt., A.U.S.
Khuon, Robert E.	Cincinnati	Capt., A.U.S.
Kile, Roy L.	Cincinnati	Surg., U.S.P.H.S.
Klein, Joseph B.	Cleveland	Capt., A.U.S.
Klopfenstein, A. R.	Toledo	Comdr., U.S.N.R.
Knierim, Harlin,	Mansfield	Lt. Comdr., U.S.N.R.
Kotte, Robert H.	Cincinnati	Lt. Col. A,U.S.
Krichbaum, William T.	North Canton	Major, A.U.S.
Krisko, Michael J.	Cleveland	Capt., A.U.S.
Kubiac, Willis T.	Cleveland	Capt., A.U.S.
Kulle, Henry F.	Cincinnati	Major, A.U.S.
Lacey, Henry B.	Columbus	Lt. Col., A.U.S.
Lacksen, Frank J.	Columbus	Lt. Col., A.U.S.
Lazarus, Lawrence	Cleveland	Capt., A.U.S.
Lefkowitz, Harry J.	Cleveland	Major, A.U.S.
Lerner, David L.	Cincinnati	Lt. Col., A.U.S.
Levin, David K.	Toledo	Capt., A.U.S.
Levine, Milton	New Boston	Major, A.U.S.
Ley, Gordon R.	Columbus	Capt., A.U.S.
Leyrer, Ralph H.	Hamilton	Lt. Col., A.U.S.
Liber, Kay E.	Canton	Lt. Col., A.U.S.
Lieberman, Harry G.	Akron	Capt., A.U.S.
Lowry, Kenneth F.	Troy	Lt. Col., A.U.S.
Malasky, Bernard S.	Cleveland	Capt., A.U.S.
Mannino, R. G.	Newark	Capt., A.U.S.
Marinelli, A. C.	Youngstown	Lt. Col., A.U.S.
Markey, Oscar B.	Cleveland	Lt. Col., A.U.S.
Marley, Harold V.	East Cleveland	Capt., A.U.S.
Marsico, Henry C.	Lorain	Capt., A.U.S.
Martin, John W.	Cleveland	Lt., U.S.N.R.
Martin, Walter E.	Columbus Grove	Major, A.U.S.
McCaffery, Robert J.	Lakewood	Major, A.U.S.
McCall, Edward W.	Portsmouth	Capt., A.U.S.
McCarthy, Kenneth C.	Toledo	Major, A.U.S.
McConkey, A. W.	Canton	Capt., A.U.S.
McGaw, Wilbert H.	Cleveland	Lt. Col., A.U.S.
McGowan, William L.	Cincinnati	Col., A.U.S.
Mehl, Lawrence B.	Akron	Lt. Col., A.U.S.
Meltzer, Jack	Cleveland	Major, A.U.S.
Merchant, Frederick T.	Marion	Major, A.U.S.
Merrill, Robert	Delta	Capt., A.U.S.
Messenger, Harold M.	Cleveland	Major, A.U.S.
Meyers, John S.	Versailles	Capt., A.U.S.
Middleton, R. H.	Youngstown	Capt., A.U.S.
Miessner, Alfred D.	Port Clinton	Major, A.U.S.
Miglets, Andrew W.	Youngstown	P.A.S., U.S.P.H.S.
Miller, Frederick H.	Dayton	Lt. Col., A.U.S.
Miller, Louis	Cleveland	Major, A.U.S.
Mills, James F.	Cincinnati	Capt., A.U.S.
Minnis, Dean H.	Amherst	Major, A.U.S.
Mirsky, I. Arthur	Cincinnati	Major, A.U.S.
Mitchell, Homer L.	Columbus	Capt., A.U.S.
Modic, Joseph L.	Cleveland	1st Lt., A.U.S.
Molle, Samuel A.	Toledo	Major, A.U.S.
Moore, John M.	Piney Fork	Major, A.U.S.
Moore, William A.	Cincinnati	Major, A.U.S.
Morgan, Chester A.	Van Wert	Capt., A.U.S.
Morgan, James E.	Cleveland	Capt., A.U.S.
Nauman, John H.	Martins Ferry	Col., A.U.S.
Neidus, M. W.	Youngstown	Major, A.U.S.
Nimitz, H. J.	Cincinnati	Col., A.U.S.
Novatney, Raymond C.	Elyria	Lt. Comdr., U.S.N.R.
O'Bell, John J.	Kingsville	Capt., A.U.S.
O'Dea, Frank J.	Cleveland	Capt., A.U.S.
Odom, R. E.	Youngstown	Major, A.U.S.
Ormond, A. P.	Akron	Lt. Col., A.U.S.
Ormond, Alfred C.	Zanesville	Lt. Col., A.U.S.
Osgood, Frederick P.	Toledo	Comdr., U.S.N.R.
Osmond, John D., Jr.	Cleveland	Capt., A.U.S.
Owen, John M.	Dayton	Capt., A.U.S.
Paisley, Ralph C.	Loudonville	Major, A.U.S.
Park, Benjamin S.	Painesville	Comdr., U.S.N.R.
Patterson, Robert J.	Hollywood, Florida	Capt., A.U.S.
(formerly of Springfield)		
Pease, H. T.	Wadsworth	Major, A.U.S.
Petcoff, Boni E.	Toledo	Lt. Col., A.U.S.
Petcoff, John E.	Toledo	Capt., A.U.S.
Pfanner, Eugene F.	Dayton	Comdr., U.S.N.R.
Phinney, James D.	Cincinnati	Major, A.U.S.
Pollack, Alexander	Columbus	Capt., A.U.S.
Quinn, Robert E.	Chillicothe	Capt., A.U.S.
Rardin, Thomas E.	Columbus	Major, A.U.S.
Reese, W. A.	Middletown	Lt. Col., A.U.S.
Renner, John A.	Youngstown	Comdr., U.S.N.R.
Riddell, Malcolm M.	Fremont	Comdr., U.S.N.R.
Risley, Clarence T.	Conneaut	Major, A.U.S.
Roberts, John L.	Toledo	Comdr., U.S.N.R.
Robertson, A. D.	Ashland	Major, A.U.S.
(formerly of Willard)		
Robertson, James E.	Wooster	1st Lt., A.U.S.
Robishaw, Arthur W.	Elyria	Comdr., U.S.N.R.
Roenigk, Henry H.	Cleveland	Capt., A.U.S.
Romoser, Wm. K.	Columbus	Capt., A.U.S.
Roof, Clyde S.	Cincinnati	Lt. Col., A.U.S.
Rosenow, Oscar F.	Columbus	Major, A.U.S.
Roszmann, Marvin H.	Washington C. H.	1st Lt., A.U.S.
(formerly of Morral)		
Rothermich, Norman O.	Columbus	Major, A.U.S.
Russell, John M.	Youngstown	Capt., A.U.S.
Sakler, B. R.	Cincinnati	Major, A.U.S.
Sauer, Richard T.	Dayton	Lt. Col., A.U.S.
Sawyer, Benjamin	Lynn, Indiana	Major, A.U.S.
(formerly of North Star)		
Scaggs, William E.	Portsmouth	Capt., A.U.S.
Schaal, James A.	Cincinnati	Major, A.U.S.
Schaffer, A. L.	East Palestine	Capt., A.U.S.
(formerly of Cleveland)		
Schneider, Richard V.	Toledo	Lt., U.S.N.R.
Schoolfield, Clarence B.	Upper Sandusky	Major, A.U.S.
Schork, Rudolph J.	Elyria	Lt. Col., A.U.S.
Schroeder, Norman C.	Kenton	Lt. Col., A.U.S.
Sebastian, Charles A.	Cincinnati	Capt., A.U.S.
Seligman, Bert	Toledo	Capt., A.U.S.
Seyler, Lloyd E.	Dayton	Lt. Comdr., U.S.N.R.
Seymour, Miner W.	Columbus	Major, A.U.S.
Sheets, Maurice V.	Newcomerstown	Comdr., U.S.N.R.
Shellenberger, Herbert	Toledo	Lt., U.S.N.R.
Shensa, Lewis S.	Youngstown	Capt., A.U.S.
Shrader, Albert M.	Waverly	Lt. Comdr., U.S.N.R.
Sims, George P.	Columbus	Comdr., U.S.N.R.
Smith, Beecher L.	Columbus	Lt. Col., A.U.S.
Smith, Earl E.	Cleveland	Lt. Col., A.U.S.
Smith, Ivan C.	Youngstown	Major, A.U.S.
Smith, Paul W.	Lorain	Capt., A.U.S.
Snyder, Roscoe H.	Toledo	Capt., A.U.S.
Sofranec, J. J.	Youngstown	Major, A.U.S.
Sovik, William E.	Youngstown	Lt., U.S.N.R.
Stack, Leonard A.	Lorain	Comdr., U.S.N.R.
Start, Gwyn H.	Toledo	Major, A.U.S.
Stas, Carl A.	Cleveland	Capt., A.U.S.
Staton, Harvey J.	West Carrollton	Capt., A.U.S.
Steyer, Clement E.	Cleveland	Major, A.U.S.
Stone, Sidney R.	Wellington	Col., A.U.S.
(formerly of Cleveland)		
Strohmenger, Warren L.	Cincinnati	Lt. Comdr., U.S.N.R.
Svoboda, Joseph E.	Cleveland	Capt., A.U.S.
Taylor, Thomas L.	Montpelier	Major, A.U.S.
Thomas, Robert L.	Columbus	Major, A.U.S.
Thompson, Roy H.	Cleveland	Lt. Col., A.U.S.
Tirey, James W., Jr.	Anna	Capt., A.U.S.
Torrence, John F.	Germantown	Capt., A.U.S.
Tschantz, Robert E.	Canton	Capt., A.U.S.
Tucker, Thomas W.	Spring City, Pa.	Lt. Comdr., U.S.N.R.
(formerly of Cincinnati)		
Underwood, Homer D.	Van Wert	Capt., A.U.S.
Van Horn, Earl C.	Springfield	Lt. Col., A.U.S.
Vollmer, J. E.	Cincinnati	Comdr., U.S.N.R.
Wade, Reynolds	Toledo	Capt., A.U.S.
Weaver, Samuel W.	Youngstown	Major, A.U.S.
Weaver, Thomas A.	Cincinnati	Major, A.U.S.
Webster, Frank B.	Bellefontaine	Lt. Comdr., U.S.N.R.
Weir, William C.	Cleveland	Lt. Comdr., U.S.N.R.
Williams, Foster M.	Cincinnati	Major, A.U.S.
Williams, Guy H., Jr.	Cleveland	Comdr., U.S.N.R.
Wilcoxon, George M.	Alliance	Major, A.U.S.
Woldman, Victor F.	Cleveland	Comdr., U.S.N.R.
Wolf, Robert E.	Uhrichsville	Major, A.U.S.
Wolford, Robert W.	Mansfield	Capt., A.U.S.
Wolpaw, Benjamin J.	Cleveland	Comdr., U.S.N.R.
Wolpaw, Ralph	Cleveland	Major, A.U.S.
Yohe, Forrest R.	Bellevue	Capt., A.U.S.
Zucker, Ralph L.	Cincinnati	Capt., A.U.S.

Military News Notes

Capt. Mason S. Jones, Columbus, is with the 454th Med. Coll. Co., at Ziegenhain, Germany.

* * *

Changes in station: Maj. James C. Vanneter, Columbus, AAB, Salinas, Calif.; Comdr. Meyer A. Zeligs, Cincinnati, U.S. Naval Hosp., Oakland, Calif.; Capt. Albert R. Zoss, Cincinnati, P.O.W. Camp, Camp McCain, Miss.; Maj. E. W. Harris, Columbus, Sta. Hosp., March Field, Calif.; Lt. Albert G. Boldizar, Cleveland, 148th Gen. Hosp., APO 244, San Francisco; Maj. Wm. S. Elliott, East Palestine, Sta. Hosp., Brookley Field, Ala.; Capt. Stephen V. Geroch, Akron, March Field Sta. Hosp., Riverside, Calif.; Capt. J. R. Bu-



THE physician now has three types of insulin available to treat diabetes. One is quick-acting but short-lived. Another is slow-acting but long-lived. The new third one—'Wellcome' Globin Insulin with Zinc—is intermediate.

Action with Globin Insulin begins moderately quickly and persists for sixteen or more hours, sufficient to cover the period of maximum carbohydrate intake. By night, activity is sufficiently diminished so that the likelihood of nocturnal reactions is minimized. A single injection daily of 'Wellcome' Globin Insulin with Zinc will control the hyperglycemia of many diabetics. When a diabetic requires insulin therapy, the physician is wise to consider all *three* insulin types.

'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its freedom from allergenic properties.

Accepted by the Council on Pharmacy and Chemistry, American Medical Association. Developed in the Wellcome Research Laboratories, Tuckahoe, New York. U. S. Patent No. 2,161,198. Available in vials of 10 cc., 80 units in 1 cc.

'Wellcome' Trademark Registered

'WELLCOME' *Globin Insulin* WITH ZINC

Literature on request.

BURROUGHS WELLCOME & CO. (U. S. A.) INC., 9 & 11 EAST 41ST STREET, NEW YORK 17, N.Y.

chanan, Youngstown, McCloskey Gen. Hosp., Temple, Tex.; Comdr. Philip H. Elliott, Zanesville, Bainbridge Naval Hosp., Bainbridge, Md.; Lt. Col. Richard W. Good, Cincinnati, Vet. Admin Thayer Gen. Hosp., Nashville, Tenn.; Capt. J. W. Norris, Columbus, chief, Gyn. and Ob. Service, O'Reilly Gen. Hosp., Springfield, Mo.; Lt. Marcel Kahn, Cleveland, 313th Gen. Hosp., APO 75, San Francisco; Lt. John M. Moore, Piney Fork, West Alexandria, Pa.; Lt. Burton G. Must, Dayton, AAF Reg. Hosp., Amarillo, Tex.; Maj. H. B. Peck, Mansfield, AAF, Roswell, N. Mex.; Maj. Thos. J. Rankin, Oxford, 3511 Elliott St., San Diego, Calif.; Capt. Franklin C. Schlueter, Cincinnati, 502nd Bomb. Gp., VH, APO 182, San Francisco, Calif.; Capt. John J. Scuderi, Akron, 326 BU, MacDill Field, Fla.; Lt. Harry Sigel, Cincinnati, 318th Gen. Hosp., APO 660, San Francisco, Calif.; Capt. Solomon Sogg, Cleveland, 311th Gen. Hosp., APO 75, San Francisco; Lt. Comdr. Thos. W. Tucker, Cincinnati, 242 Bridge St., Spring City, Pa.; Capt. Roy B. Kleinman, Cincinnati, 229th Gen. Hosp., APO 713, San Francisco, Calif.

* * *

Medical activities of Carlisle Barracks, Pa., and the Medical Section and certain portions of the basic training program at the Army Service Training Center, Fort Lewis, Wash., are being transferred to Fort Sam Houston, Texas. The move, involving approximately 6,000 enlisted men and officers, will be completed by March 15. Carlisle Barracks, which has been a center for Medical Department training for about a quarter of a century, will be continued as an Army post and as the location of the Army Information School.

* * *

Awaiting transportation at Isahaya, Japan, where he is with Corps Evac. Hosp. 3, Lt. Comdr. E. R. Torrence, Troy, is hopeful that he'll be on terminal leave soon.

Our apologies to Maj. John W. Viktoryn, Cleveland! He was listed as a captain in the roster of discharged medical officers in the January issue. We now know that he had been a major for two years while overseas.

* * *

Maj. J. A. Rudolph, Columbus, has been appointed chief of the medical service at Oliver General Hospital, Augusta, Ga., selected by the War Department to be one of the nine permament General Hospitals in the United States. It has been awarded the Meritorious Service Wreath for outstanding service during the war. A book by Dr. Rudolph entitled "What You Don't Know May Hurt You", being published by Dorrance & Co., Philadelphia, is to reach the bookstands by March 1.

Pending expansion of Veterans Administration facilities for the care of tuberculous patients, Moore General Hospital, Swannanoa, N.C., has been designated as a specialty center for tuberculosis. The large number of examinations at separation centers has lead to the discovery of cases of tuberculosis at a rate temporarily exceeding the capacity of Fitzsimons and Bruns General Hospitals and tuberculosis hospitals of the Veterans Administration.

WIN PROMOTIONS

Conn, James J.	Columbus	Capt., A.U.S.
Jones, Mason S.	Columbus	Capt., A.U.S.
Zeligs, Meyer A.	Cincinnati	Comdr., U.S.N.R.

Policy on Preceptorships Issued By Board of Ophthalmology

The following statement has been issued by Dr. S. Judd Beach, secretary of the American Board of Ophthalmology:

"In regard to the substitution of a preceptorship for residency in an ophthalmic hospital, the American Board of Ophthalmology has always accepted such training in favorable cases. During the present over-crowding of facilities, the Board expects to take a liberal attitude regarding the requirements for training.

"It should, however, be pointed out that neither a residency nor a preceptorship suffices in itself to meet the requirements of the Board. Each case will still be judged on its merits in determining fitness for examination.

"In entering upon preceptorship certain conditions should be kept in mind. First the student will profit most after a sound course in the basic sciences of physiology of the eye and of vision, optics, pathology, bacteriology, chemistry, pharmacology, the relation of the eye to general disease, anatomy, embryology, and neurology.

"This is essential for a residency, more so for a preceptorship. While men have been accepted from preceptors not diplomates of the Board, it is obvious that the Board has more information about those teachers who have passed its examinations.

"Any preceptor should understand that he is assuming a responsibility in taking a student and is not merely obtaining help in the drudgery of his office. He should be willing to give time to clinical training and the use of apparatus, slit-lamp, ophthalmoscope, tonometer and to directing the student's practice in surgery on animal eyes, assisting in operations and ultimately in the performance of them.

"To cover the same amount of ground will take much longer in a preceptorship than in a residency and students should accept opportunities to take hospital positions of all sorts as they become available."

Why do Tom, Dick and Harry need Vitamin D?



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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

NATIONAL A.M.A. PROGRAM NEEDS YOUR SUPPORT

Elsewhere in this issue appears an article regarding recent action of the Board of Trustees and Council on Medical Service and Public Relations of the American Medical Association, establishing a national coordinating program for voluntary prepaid medical care plans and amplifying the policy of the A.M.A. on health services generally.

The A.M.A. is to be congratulated on this progressive and far-reaching action. It will be a big boost for the voluntary prepaid medical care movement, as it places the weight and influence of the A.M.A. behind such plans. It reveals that the medical profession has an affirmative and constructive national health program—something which the profession has had but which, up to now, has not received sufficient impetus.

Read the article carefully. Tell your acquaintances and patients about it. Inform your Congressman. The job of the individual doctor, each county and each state medical society is to get behind this national plan. The way to do this is to give more than lip service to progressive programs at the state and local level which are in line with A.M.A. statement of policies.

"THIRD DIMENSION OF SOCIAL PROGRESS"

Did you happen to read the article by Raymond Moley, syndicated by the Associated Newspapers, Inc., and headlined, "Hoover Provides Third Dimension of Social Progress", by the *Columbus Dispatch?*

The article refers to a short speech by Hoover at a Lincoln Day dinner during which the former president stated what he believes should be the philosophy of the Republican Party. To quote:

"Our philosophy must fully embrace the concept that man can accomplish more by co-operation outside the government than by coercion from within the government. It is this co-operation among free men aligned to public interest that releases the energies of the people for creative achievement and abundant production. The tens of thousands of community committees, local governments, labor unions, commercial associations, farm organizations and our host of other free institutions can do a million services in the public interest every year which Statism will wither on the vine.

"There are fields where co-operation can be properly aided by government, but government swollen with power and laden with burdens becomes something above and apart from the governed. It becomes the enemy of the governed increasing its prerogatives with fanatical zeal."

No matter what you may think of Hoover or Moley; regardless of your party affiliation, the statement reproduced above deserves your studious consideration, especially in these days when great power and pressure is being exerted to engulf the practice of medicine and members of the medical profession with a gigantic scheme of governmental bureaucracy.

The medical profession through its own organizations is endeavoring to develop programs which, as Mr. Moley puts it, "will avoid the dead hand of governmental tyranny through the co-operation of free men". These programs, among them that which would spread voluntary prepaid medical care plans throughout the entire nation and that which would establish co-operation between the medical profession and government in the fields of health and medical service, deserve the all-out support of the medical profession and the hearty endorsement and help of the public at large. These programs adhere to what Mr. Moley has aptly termed "the third dimension of social progress".

A REAL PROJECT IN FIELD OF PUBLIC RELATIONS

Our hat is off to the Cleveland Academy of Medicine and the *Cleveland Press* for cooperating in a health education project which should prove to be of far-reaching importance.

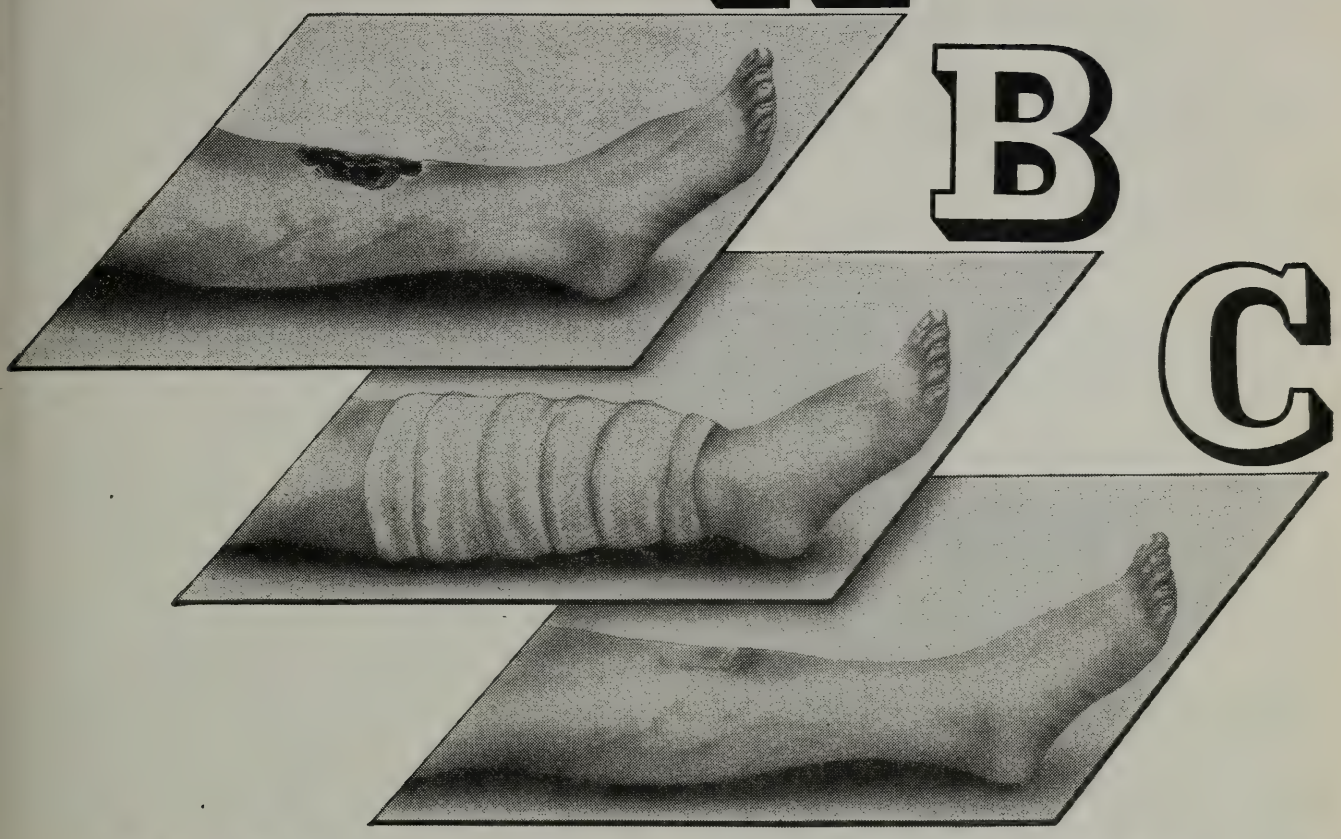
The *Press* with the aid of the Health Education Committee of the Academy is publishing a series of 65 weekly articles under the title, "Your Doctor". The articles are by well-known Cleveland physicians and deal authoritatively with the cause, symptoms, and treatment of some disease.

This is good public relations on the part of the medical profession and should serve as an example for all county medical societies. David Dietz, science writer for the Scripps-Howard newspapers with which the *Cleveland Press* is affiliated, hit the nail on the head in the introductory article of the series, when he said:

"The series is unique in the history of modern journalism and modern medicine. It is a genuine public service and testifies to the alert and co-operative spirit of Cleveland's medical men.

"Twenty-five years ago, when I first started to write a science column for this newspaper, medical men throughout the country still looked askance at the idea of appearing in print. For one thing, medical men feared that they would not be reported accurately. For another, the medical

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man who spoke for public print was regarded with suspicion by his colleagues.

"Today that attitude is breaking down. The American Medical Association for more than a decade has welcomed accredited writers to its meetings. Doctors, generally, have realized the value of having medical knowledge transmitted to the public.

"The present series of articles, however, represents a co-operative venture upon the part of a city's medical profession such as has never been attempted before.

"The 65 articles should prove a gold mine of valuable information for the reader.

"The effect of these articles should be a better informed and healthier city."

If this kind of cooperation between the press and the medical profession can be achieved in Cleveland, it can be achieved in all other parts of Ohio. Take up the question with your society at the next meeting.

IT'S ABOUT TIME FOR OHIO TO WAKE UP

On several occasions we have charged that Ohio is accepting too much money from the Federal Government for activities which are actually the responsibility of this state and that as long as Ohio follows this policy it may expect to be led and shoved around by the Federal Government.

For this reason, we're intrigued by a recent communication transmitted by Dr. Roger E. Heering, Ohio Director of Health, to all state and territorial health officers, analyzing data supplied to him by the health departments of other states in response to a request which he had made several months ago.

The material collected by Dr. Heering tabulates the funds which are made available in each state for public health services by cities and counties, by the state government and by the Federal Government, exclusive of E.M.I.C. funds.

A comparison of Ohio with other states shows Ohio in the second division. But of special significance is the breakdown of the sources of the funds spent in Ohio for health services when figured on a per capita and a percentage basis.

For example, the study shows that the cities and counties of Ohio are spending 51 cents per capita or $3,608,046.69 for health services; the state government, 7 cents per capita or $526,-075.00; the Federal Government for activities within Ohio, 20 cents per capita or $1,394,280.20, not including E.M.I.C. money.

Ohio is not too far out of line with the majority of states as regards funds made available by local political subdivisions. However, Ohio is very deficient as compared to a majority of states in the degree to which it has assumed responsibility at a state level. Although Ohio is fourth among the states in wealth, it is among the last half dozen states in state expenditures for health activities.

A comparison of state expenditures to Federal expenditures shows that in Ohio for every one dollar of state money available, three dollars of Federal funds are being spent in Ohio. In most of the states this ratio is at least one state dollar to two Federal dollars or better.

We congratulate Dr. Heering for releasing this revealing information and on his statement that the deficiency of state funds available in Ohio when compared to the amount of Federal money spent, "suggests a particularly unhealthy situation".

Amplifying this point, Heering said:

"In Ohio we find it necessary to support entire divisions of our State Department with Federal funds. It is my feeling that a state should at least support her central administration, leaving Federal funds for distribution to local health districts economically unable to support adequate health services."

These divisions are those of nursing, venereal diseases, industrial hygiene, and tuberculosis, plus the plumbing and milk inspection sections of the Division of Sanitary Engineering.

Just imagine! Ohio is accepting a hand-out from Washington for the operation of these important phases of its public health program.

We would go Dr. Heering one better. Ohio not only should adequately support its central administration but also should provide funds for helping needy health districts, making the use of Federal funds unnecessary except for activities which are of national or inter-state significance.

As we have said before, those who don't want the Federal Government taking over activities and responsibilities which rightfully belong to Ohio, and should be assumed by Ohio, had better get busy with the job of putting Ohio's own house in order.

Unless, and until, sufficient public sentiment is aroused, the Legislature inconsistently will continue to short-change the State Health Department and continue to let Uncle Sam foot the bills but at the same time yell bloody murder about "state's rights", "Federal dictation", etc.

It's about time for Ohio to wake up and do the job which it is capable of doing and can afford to do.

LET'S GIVE THE DISABLED G. I. A REAL BREAK !

The Washington Bureau of the *Cincinnati Enquirer* has reported U. S. Senator William A. Stanfill, Kentucky, as having said on the floor of the Senate in an argument for location of a Veterans hospital at Fort Thomas, Ky., instead of Cincinnati near the University of Cincinnati College of Medicine: "We do not want our veterans treated by students in a medical school".

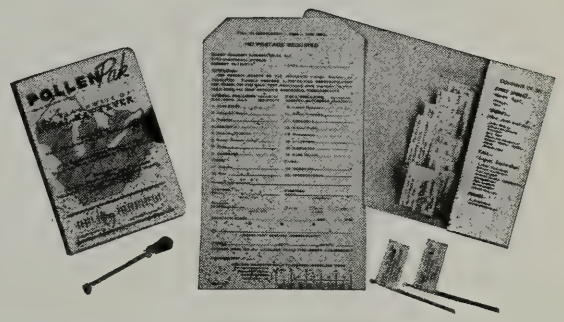
Whereupon, Senator Stanfill revealed a total ignorance of medical schools and hospital management and a lack of understanding of why it

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would be of vital importance to disabled veterans to have veterans' hospitals located near a medical center.

We doubt if there is a medical school in the country which has offered to cooperate with the Veterans Administration (some 60 have) because it is running out of work to do or is seeking broader fields of activity. Why then, have they volunteered to assume the responsibility of giving the V.A. a lift? Simply because they realize that by coordination of the V. A. hospitals with medical schools and through location of V. A. hospitals in medical centers, the disabled veteran will get a high quality of medical care.

Congressional Record, please copy!

WHAT CAN'T HAPPEN IN THE GOOD OLD U. S. A. ?

According to the Associated Press, the British Minister of Agriculture has told British farmers that those who fail to cooperate with the government's planned agricultural program run the risk of having their lands confiscated at a "valuation" to be fixed by the government and the government intends to see that the land is "properly farmed, managed, and equipped".

It can't happen here? Says you!

Have you ever stopped to think about how many government-owned businesses there are already in the good old U. S. A. ?

Instead of kidding ourselves, let's put an end to a lot of this government-in-business (and in medicine) stuff.

CHEST X-RAY SURVEYS NEED LOCAL MEDICAL GUIDANCE

According to the Ohio Public Health Association, chest X-ray surveys of apparently healthy persons have been conducted in 52 Ohio counties during the past several years and the demand for such programs is increasing.

These projects should have the support of the local medical profession for several reasons: First, they must have the guidance of physicians; secondly, they are worthy public health programs; thirdly, they will benefit persons who should have prompt professional care; finally, they will stimulate persons needing treatment to see their physicians before it is too late.

The Council of the State Association has endorsed the principle of mass chest surveys for the detection of pulmonary tuberculosis for public health purposes, providing such surveys are conducted in line with the following principles:

"Agencies conducting such surveys should seek and receive the approval of the county medical society in the community concerned which should appoint a committee to act as a consultative and advisory body to the surveying agency.

"The films should be examined by physicians who are trained and competent to interpret radiographs of the chest.

"Cases showing abnormalities should be immediately referred for further study and care to local physicians, or, when this is impractical, to other available agencies.

"The question of fees for roentgen interpretation of films in surveys for public health purposes should be determined locally."

Has your County Society a committee such as the one suggested above? Has your County Society taken an active interest in such projects in your county? If not, it should.

THE COST OF EXPANDED SOCIAL INSURANCE

When discussing the Wagner-Murray-Dingell proposal with your acquaintances, don't hesitate to tell them that this measure, if enacted, would cost them plenty.

Here are some data and figures which you can quote, prepared by the Insurance Economics Society of America, Chicago:

"It is unfortunate but true that the advocates of an expanded program of compulsory social insurance in the United States have consistently avoided all questions of costs. It is equally unfortunate that, in terms of direct tax payments, the cost of the proposals seems low to the average individual, who is in no position to compute the grand total and thus arrive at a basis upon which the consequences to the nation can be assessed.

"In the absence of any cost estimates by advocates of an expanded system of compulsory social insurance, the following tabulation, prepared from estimates of Research Council for Economic Security, is presented. Included are the services contemplated by the terms of the Wagner-Murray-Dingell bill and certain other services recommended in the report of the National Resources Planning Board.

"Old-Age and Survivors Insurance Benefits Ultimate annual cost when system reaches maximum proportions (about 1975)	$6,200,000,000
"Other Retirement Benefits Includes railroad employees, veterans, public employees, etc.—annual	1,500,000,000
"Medical Care Includes health insurance, disability and maternity provisions, hospitalization benefits and a stepped up program of medical care (over 1941 program)—annual	5,100,000,000
"Unemployment Insurance—annual	1,050,000,000
"Public Aid (Relief and Assistance)—annual	1,600,000,000
"Additional Services Includes public works, youth programs, workmen's compensation, school lunches, and surplus commodities—annual	4,475,000,000
Total	$19,925,000,000

"It can be seen that some of this cost does not represent new expense. Parts of some of the programs listed are already in operation. The cost of medical care is not wholly new—we are today spending through public and private sources at least 3 billion annually for medical care.

"This amount, nearly $20 billion annually, if

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assessed against a working force of 60 million men and women (a higher figure than may be expected for a number of years) would mean a cost per wage-earner of $333.00 a year. Only a part will be collected in the form of direct taxation, making the cost appear much lower than that. But, actually, those who are gainfully occupied will have to pay—whether directly or indirectly— now or later.

"But that is not the whole story. From experience, not only here, but particularly in foreign countries, where it has been much longer, we know that expansion goes on and on—a juggernaut that cannot be stopped. Thus the size of the program proposed today does not give any hint of what the size may be a generation hence.

"A valid question is whether the nation can bear this cost without too serious results, particularly with respect to its economic progress and its multiplicity of opportunities. Too few people have considered social security, in the forms currently proposed, in that light."

HOMES FOR CARE OF AGED SHOULD BE CAREFULLY CHECKED

Writing in *Public Assistance Statistics*, publication of the Ohio Department of Public Welfare, Mrs. Zoe McCaleb, R.N., supervisor of home inspection, discusses licensed homes for the aged in Ohio. She makes the following pertinent observations, among others:

"Few commercial homes are equipped with nursing personnel to care for patients needing nursing care only, and only a small per cent of the county homes provide hospital facilities. It frequently happens that the invalid and chronic patient must remain in a boarding or rest home where service is most inadequate. . . .

"There is a desperate need for chronic disease hospitals. Until the communities recognize this need to provide for patients requiring medical and nursing care, provisions for the aged will be inadequate. . . .

"Commercial homes for the aged are able to render a valuable service for aged persons, providing this service is limited to ambulatory and senile persons requiring protection and shelter care rather than hospital, medical, and nursing care. . . . Each community needs a variety of services in order that aged persons can be cared for according to their needs, the determination of which should be based on a medical diagnosis."

This is sound reasoning and advice. There are two vital points. First, physicians endeavoring to find boarding or rest homes for aged patients should make sure that the home selected offers the services which are required, and that the home is under good professional supervision, in event the patient needs medical or nursing care. Second, all communities should take inventory as to the need for a chronic disease hospital.

INDOCTRINATION COURSE FOR MEMBERSHIP APPLICANTS

The Council of the Los Angeles County Medical Society (California) has established an indoctrination course for applicants for membership through which those seeking membership will be required to attend lectures on ethics, malpractice problems, laws governing medical practice, public health laws and regulations, medical history, the social and economic aspects of medicine, etc.

The idea has much merit. Obviously, many of these subjects should be covered during medical school training but they are not—at least not in most schools. Therefore, the job should be done by medical organization.

It would be a good idea for some of the county medical societies in Ohio to give the plan a whirl. By doing so they will be helping the physician who is starting practice and at the same time, they will be strengthening the ranks of the profession.

Mississippi Valley Medical Society 1946 Essay Contest

The Mississippi Valley Medical Society is resuming its annual Essay Contest which has not been held during the war. In 1946 it offers a cash prize of $100.00, a gold medal, and a certificate of award for the best unpublished essay on any subject of general medical interest (including medical economics) and practical value to the general practititioner of medicine. Certificates of merit may also be granted to the physicians whose essays are rated second and third best. Contestants must be members of the American Medical Association who are residents of the United States. The winner will be invited to present his contribution before the next annual meeting of the Mississippi Valley Medical Society to be held in St. Louis, Mo., September 25, 26, 27, 1946, the Society reserving the exclusive right to first publish the essay in its official publication—the *Mississippi Valley Medical Journal* (incorporating the *Radiologic Review*). All contributions shall not exceed 5000 words, be typewritten in English in manuscript form, submitted in five copies and must be received not later than May 1, 1946.

Further details may be secured from: Harold Swanberg, M.D., Secretary, Mississippi Valley Medical Society, 209-224 W.C.U. Building, Quincy, Illinois.

The Upjohn Company's collection of paintings, which has been used to illustrate the company's educational health program, "Your Doctor Speaks", is now on a tour of the country and will appear at the Dayton Art Institute, Dayton, during the month of March.


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In Memoriam

Geza Manuel Aczel, M.D., Cincinnati University of Budapest, Hungary, 1909; aged 64; died Jan. 16; member of the Ohio State Medical Association and Fellow of the American Medical Association. Dr. Aczel was born in Budapest, Hungary, and studied medicine in Berlin, Budapest, and Vienna before coming to the United States 20 years ago. After practicing medicine in the Caribbean area and in Louisiana, he retired three years ago and moved to Cincinnati. Surviving are his widow, two brothers, and two sisters.

Belle Jane Allen, M.D., Kasauli, India; Boston University School of Medicine, 1904; aged 84; died Jan. 2; former resident of Bellefontaine. Dr. Allen taught music from 1883 until 1886, after graduation from Ohio Wesleyan University. Entering missionary training in 1887, she was sent to Japan the following year, where she served until 1898. After returning to the States, Dr. Allen enrolled in Boston University Medical School, and took postgraduate work at the University of Vienna. An appointment to the Butler Memorial Hospital in India was followed by additional postgraduate work at Columbia University and at the School of Tuberculosis, Saranac Lake, N. Y. Four years of work at the Hospital for Mental and Nervous Diseases, Westboro, Massachusetts, was followed by study at the Tropical Diseases Hospital in London. Later Dr. Allen became vice-president and chairman of medicine at the Woman's Christian Medical College, Ludhiana, India, where she resigned in 1931. After returning to this country, she went again to India in 1933, where she remained continuously except for a year spent at Columbia University in 1937. Dr. Allen retired from practice in 1943. Surviving is one sister.

Byron Gracey Anderson, M.D., Uhrichsville; Starling Medical College, Columbus, 1886; aged 88; died Jan. 17; former member of the Ohio State Medical Association and the American Medical Association; honorary member of the Tuscarawas County Medical Society. Dr. Anderson had practiced medicine in Harrison and Tuscarawas counties for 59 years. His widow and three children survive.

Daniel William Davis, M.D., Akron; Starling Medical College, Columbus, 1895; aged 80; died Feb. 5; member of the Ohio State Medical Association; Fellow of the American Medical Association. Dr. Davis started his medical practice at Wellston in 1898, and moved to Akron in 1919. During World War I he served as a captain in the medical corps. He is survived by his widow and two sons, Dr. Roger Q. Davis, Akron, and Lt. Comdr. Adrian E. Davis, a physician in the U. S. Navy; one brother and a sister.

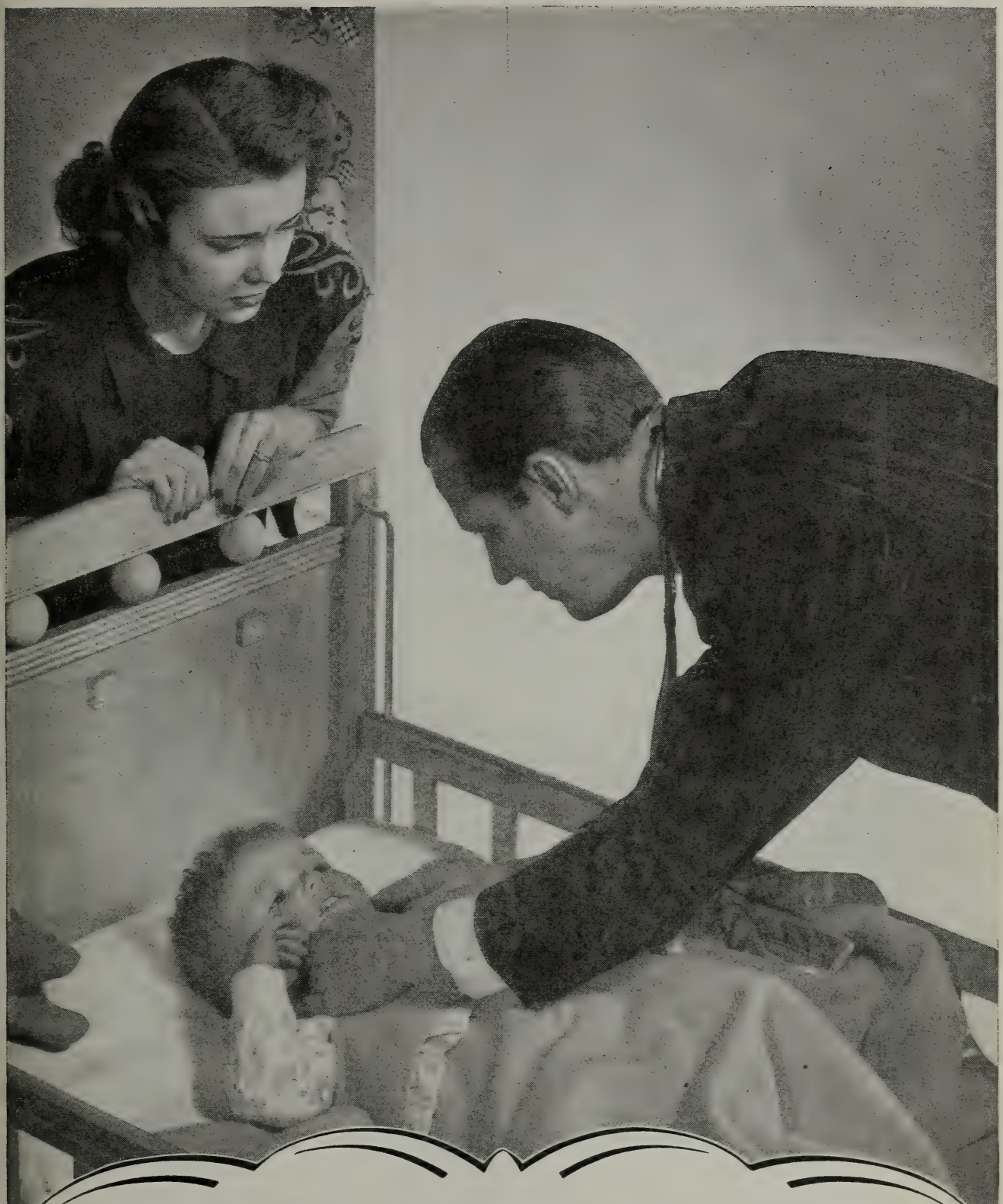
DIED WHILE IN MILITARY SERVICE

Paul Mitchell Glenn, M.D., Cleveland; Western Reserve University School of Medicine, Cleveland, 1935; aged 39; member of the Ohio State Medical Association; Fellow of the American Medical Association. Dr. Glenn, who was a major in the Army of the United States, died December 21 at the Lawson General Hospital, Atlanta, while on active duty in the service of his country. Previous to his entry into the army, Dr. Glenn was an instructor in medicine at his alma mater. When this country entered the war, he was attached to the Fourth General Hospital in Melbourne, Australia, until illness forced his return to the States in 1943. He then was stationed at the Finney General Hospital, Thomasville, Ga., there to carry on his work despite an illness which terminated fatally. Dr. Glenn was a member of the Alpha Omega Alpha fraternity. He is survived by his widow, one son, and a daughter.

* * *

Gordon Horatio Hammill, M.D., Cleveland; Ohio State University College of Medicine, Columbus, 1928; aged 41; member of the Ohio State Medical Association and the American Medical Association. Dr. Hammill, who was a captain in the Army Medical Corps, was killed October 4 in an air accident over Japan. He was a flight surgeon assigned to the 21st Troop Carrier Squadron and was on his second tour of overseas duty. He served in the southwest Pacific from August to December, 1943, and returned to the Pacific area in September, 1944. He had been in the army since September, 1942, and had seen service on New Guinea, Leyte, and Biak. Dr. Hammill had established practice in Euclid with his wife, Dr. Edith Wallace Hammill, in 1929. Surviving are his widow and two sons.

Eleanora Sophronia Everhard, M.D., Dayton; University of Michigan Medical School, Ann Arbor, 1896; aged 79; died Jan. 25; member of the Ohio State Medical Association and the American Medical Association. Dr. Everhard retired in 1942 after having practiced medicine in Dayton for about 40 years. Active in health, civic, and cultural affairs, she was vice-president of the



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Montgomery County Medical Society in 1927; former chairman of the American Medical Association committee of public health education for women; an organizer of the College Women's Club of Dayton; member of the Dayton Woman's Club, Civic Music League, YWCA, Art Institute, Professional Women's Club, Altrusa Club, the Oakwood City Council and Board of Health, and the Presbyterian Church. Surviving is one brother, Dr. Frank Everhard, Ripon, Wisconsin.

Ella Thompson Fast, M.D., Paulding; Cincinnati College of Medicine and Surgery, 1897; aged 74; died Dec. 31. Dr. Fast retired in 1933 after having practiced medicine in Paulding for 36 years. An artist as well as a physician, she had produced a number of oil paintings. Surviving are her husband, Dr. L. R. Fast of Paulding, two daughters, and two brothers.

Ward Anderson Fritz, M.D., Wooster; Western Reserve University School of Medicine, Cleveland, 1928; aged 47; died Jan. 19; member of the Ohio State Medical Association and the American Medical Association. Dr. Fritz, former president of the Wayne County Medical Society, had been discharged from the U. S. Army Medical Corps December 10. He had served for more than five years and held the rank of major. He had resumed private practice in Wooster only ten days before his death occurred. Dr. Fritz was a former All-Ohio center on the Wooster College football team; a member of the Masonic and I.O.O.F. lodges, the American Legion and Veterans of Foreign Wars; and had served on the local school board. Surviving are his widow, two sons, a daughter, and three brothers.

Wendell Holmes Montgomery, M.D., Louisville; University of Pittsburgh College of Medicine, 1921; aged 54; died Jan. 20; member of the Ohio State Medical Association; Fellow of the American Medical Association. A veteran of World War I, Dr. Montgomery was a member of the American Legion, the Masonic lodge, Nu Sigma Nu medical fraternity, and the Reformed Church. Surviving are his widow, a brother, and a sister.

Joseph Lorain Reed, M.D., Wilmot; Ohio Medical University, Columbus, 1897; aged 78; died Jan. 17; former member of the Ohio State Medical Association and the American Medical Association. Dr. Wilmot practiced medicine in Canton until 1920, when he retired due to ill health. He was a member of the Eagles and Masonic lodges and the Methodist Church. A son survives.

Edwin Forrest Shaffer, M.D., Columbus; Ohio State University College of Medicine, Columbus, 1909; aged 60; died Jan. 26. A former U. S. Army physician, Dr. Shaffer retired with the rank of colonel in 1943. He was awarded the Silver Star and the Croix de Guerre while serving with the 37th Division in World War I, and participated in World War II until his retirement. He was a member of the Masonic lodge. Surviving are his widow, one son, a daughter, his mother, two brothers, and a sister.

Cornelia Anna Stoeltzing, M.D., Cleveland; University of Wooster Medical Department, Cleveland, 1906; aged 63; died Jan. 12; member of the Ohio State Medical Association; Fellow of the American Medical Association. Dr. Stoeltzing retired in 1936 after practicing medicine in Cleveland for 20 years. She was one of the founders of the Woman's Hospital and was president of its board of trustees for five years. Dr. Stoeltzing was a member of the Presbyterian Church.

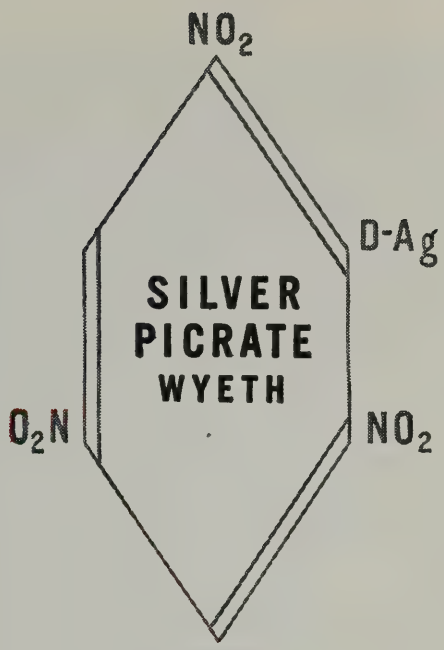
Abraham Strauss, M.D., Cleveland; Johns Hopkins University School of Medicine, Baltimore, 1912; aged 59; died Jan. 30; member of the Ohio State Medical Association; Fellow of the American Medical Association, and of the American College of Surgeons; Diplomate of the American Board of Surgery and American Board of Radiology; member of Radiological Society of North America, Inc. and the American Radium Society. Dr. Strauss, chief of the department of surgery, Mount Sinai Hospital, since 1940, had practiced medicine in Cleveland since 1915. He became affiliated with Mount Sinai Hospital in 1916, and, except for his military service as a captain in the Army Medical Corps during World War I, he maintained his staff association until his death. Dr. Strauss developed a tumor clinic at the hospital. A delegate to the Ohio State Medical Association in 1933 and 1940, he was also a trustee of the Cleveland Health Museum and of the Cleveland Medical Library; member of the B'nai B'rith, the Temple, and the Zionist Organization of America. Surviving are his widow, three daughters, a brother, Dr. Israel Strauss of New York, and three sisters.

Walter Sherman Stuckey, M.D., Wapakoneta; Fort Wayne College of Medicine, Ft. Wayne, 1892; aged 79; died Jan. 24; former member of the Ohio State Medical Association and the American Medical Association. Dr. Stuckey, who had practiced for 52 years, was former coroner of Auglaize County and had served as president of Wapakoneta City Council. He was president of the Auglaize County Medical Society in 1920 and delegate to the Ohio State Medical Association in 1924 and 1925.

Harry Fuller Waite, M.D., Cleveland; New York University Medical College, New York, 1897; aged 74; died Jan. 26. Dr. Waite was president of the Picker X-Ray Corporation, Waite Manufactutring Division, Cleveland. He was an honorary member of the Radiological Society of North America and recipient of the Modern Pio-

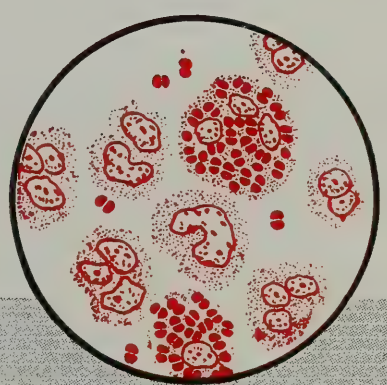
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neer Award for contribution to improvement of American standards of living. His widow survives.

Charles Thomas Way, M.D., Cleveland; Western Reserve University School of Medicine, Cleveland, 1921; aged 59; died Feb. 4; member of the Ohio State Medical Association; Fellow of the American Medical Association; life member of the American College of Physicians; member of the American Board of Internal Medicine. Dr. Way had been consulting director of medicine at Saint Luke's Hospital, Cleveland, for a number of years until his retirement last October. He began practicing medicine in Cleveland in 1922, and served, until his retirement, as a member of the faculty of the Western Reserve University School of Medicine. He was president of the Academy of Medicine of Cleveland in 1940; a member of Presbyterian Church and the Masonic lodge. Surviving are his widow, two sons, two daughters, and two sisters.

Firman M. Wurtsbaugh, M.D., Richwood; Eclectic Medical College, Cincinnati, 1908; aged 73; died Jan. 22; member of the Ohio State Medical Association and the American Medical Association. Dr. Wurtsbaugh, who was serving as health commissioner of Madison and Union counties at the time of his death, had practiced medicine in Union county for more than half a century. He was president of the Union County Medical Society in 1929 and 1930; president of the Union County Board of Health from 1931 to 1942; member of the Masonic lodge, the Lions club, and the Methodist Church. Surviving are one son and a daughter.

Hospital Planning Books Available

To offer guidance to organizations and groups contemplating the establishment of new hospital facilities in their communities, a group of articles reprinted from the 1945 *Hospital Review* is now available from the American Hospital Association, Chicago 10, Illinois. Discussions of important phases of hospital organization and construction, published in three pocket-sized booklets, are entitled: "Measuring the Community for a Hospital" (early considerations in planning); "Organization of the Medical Staff", and "The Governing Board of the Hospital".

A fourth article, "The Administrative Aspects of Hospital Planning", is designed to assist the building committee when it begins work with the architect. This article, though unavailable in reprint form, may be found in the complete Book I of the 1945 *Hospital Review*, "The Individual Hospital".

The 18th Annual Postgraduate Assembly of the Mahoning County Medical Society will be held at the Hotel Pick-Ohio, Youngstown, April 17.

Research Projects Begun by Division of Mental Hygiene

State Welfare Director Frazier Reams has announced that the State Board of Control has made available to the Division of Mental Hygiene the sum of $25,000 for research in the field of mental diseases. The money will be divided between several research projects designed to investigate mental health problems from the biological, medical, and sociological points of view. Dr. Edward J. Humphreys, chief, Bureau of Prevention and Education, Division of Mental Hygiene, will direct and coordinate the research work.

A study to be undertaken at the Longview State Hospital by Lt. Col. Albert B. Sabin, Cincinnati, will study the role of virus diseases in the production of schizophrenia. Dr. E. A. Baber, superintendent of Longview State Hospital, in outlining the work, states that using serum of patients, large scale immunity tests will be conducted with mice to propagate the viruses in an attempt to discover if virus infections contribute to the development of this mental disorder.

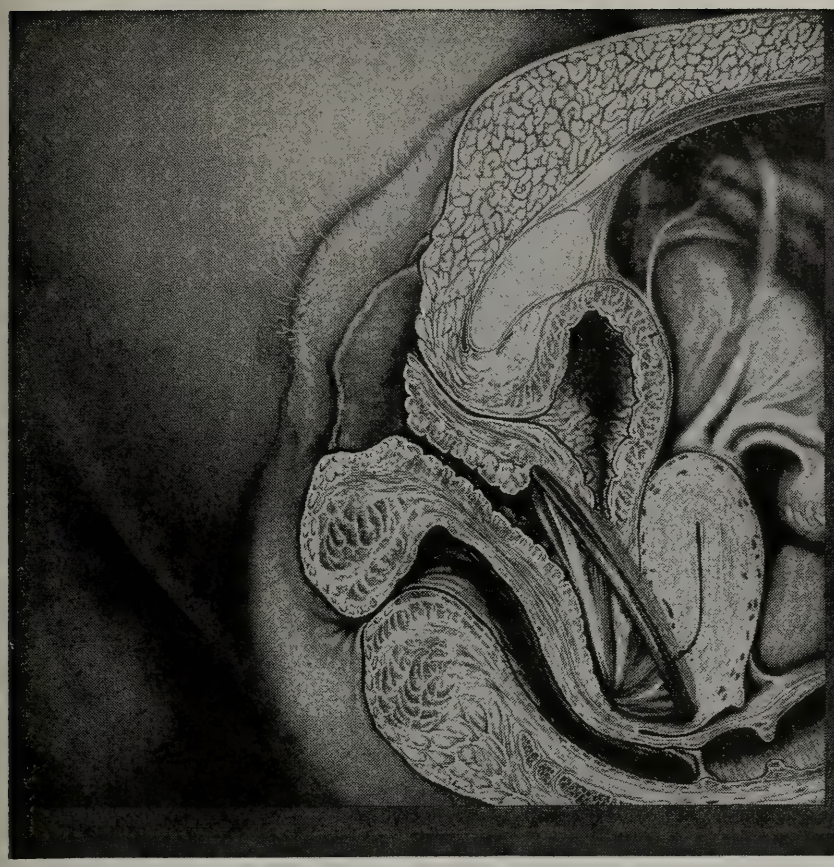
Under the direction of Dr. Lawrence H. Snyder, geneticist at Ohio State University, and Dr. Warren Wheeler, director of laboratories, Children's Hospital, Columbus, the "RH" factor in the human blood will be studied to uncover new facts about the causes of mental deficiency. Intensive study of such cases will be undertaken with patients from the Columbus, Orient, and Apple Creek State Schools, and in the relatives of these patients elsewhere in the state.

Another research project will investigate the relation of the blood vessel system of the body and mental disorders. This study will be conducted at the Massillon State Hospital of which Dr. Arthur G. Hyde is superintendent.

The mental institution as a whole will be studied to determine the efficiency of its various functions, the relation of the institution to the community, and the causes and effects occurring in an individual patient's life both before and following his admission to the institution. This study, planned at the Columbus State Hospital, of which Dr. J. F. Bateman is superintendent, will mean much in terms of future planning of care, training, treatment, and research in state hospitals and mental institutions.

An inventory of mental health facilities in certain Ohio communities will be undertaken to determine where the services of mental hygiene clinics, receiving hospitals, and other mental health services are most needed. This project will be conducted by John A. Reimers, professor, School of Administration, and Arthur R. Mangus, professor, Dept. Rural Economics and Rural Sociology of Ohio State University.

New psychological tests developed at the Columbus State Hospital, by Dr. M. C. Sexton, to aid in diagnosing mental patients, will be written.



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In view of the preponderant clinical evidence in its favor, we suggest that physicians will afford their patients a high degree of protection by prescribing the diaphragm and jelly technique.

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1. Dickinson, R. L.: Techniques of Conception Control. Baltimore, Williams and Wilkins Co., 1942.
2. Eastman, N. J., and Scott, A. B.: Human Fertility 9:33 (June) 1944.
3. Warner, M. P.: J. A. M. A. 115:279 (July 27) 1940.

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Revised Code of Regulations Governing Ohio Tuberculosis Hospitals Adopted by Health Council; Effective Feb. 15

A REVISED Code of Regulations Governing Tuberculosis Hospitals, adopted by the Ohio Public Health Council on January 13, 1946, became effective February 15.

The new regulations will be used by the Ohio Department of Health, Tuberculosis Division, as the basis for the approval or disapproval of Ohio's tuberculosis hospitals.

Adoption of the code is another step toward modernizing and improving Ohio's over-all tuberculosis program.

REPEALS OLD RULES

Repealing former regulations of the Ohio Sanitary Code relating to this subject, the revised code defines a "tuberculosis hospital", provides a method for inspection and certificating of tuberculosis hospitals, establishes standards for general facilities, describes the duties of the officials, and sets up uniform classifications of patients as to type of disease, extent of lesions, and degree of activity. (See page 826, September, 1944, issue of *The Journal*, for classification regulations.)

Also, the revised code includes the following provisions of special interest to physicians as they relate to the medical and allied services within such institutions:

Regulation 63. (Medical Staff).

1. The medical superintendent should be a reputable licensed physician with at least three years' experience in a recognized tuberculosis hospital or a total of three years' experience in tuberculosis work, two years of which should have been spent in a recognized tuberculosis hospital. In institutions of 100 or more beds, the position of medical superintendent should be full-time.

2. There should be, in addition to the medical superintendent, at least one full-time resident physician for the first 100 resident patients, and one additional full-time physician for each 50 additional patients or the major fraction thereof.

3. Where the sanatorium assumes entire responsibility for the tuberculosis control service in the area, there should be, in addition to the physician required for the medical administration of the sanatorium, one full-time physician for each 100 resident deaths in the community from tuberculosis or major fraction thereof.

4. Each member of the resident staff should be a graduate of a grade A medical school and should have had a rotating internship in a general hospital.

5. The services of consultants in internal medicine, general surgery, and in the medical and surgical specialties should be utilized.

Regulation 64. (Medical Services).

1. Every patient should be seen by a physician within 24 hours after admission.

2. The initial physical examination should include not only the chest and upper respiratory tract but the entire body.

3. Chest X-ray examinations should be made on admission, as frequently as indicated in the course of treatment, and on discharge. X-ray examinations of resident patients should be made at least every three months and more often if necessary.

> Exception: In the case of the chronic fibroid tuberculous patient not more than six months should elapse without X-ray.

4. Patients who are acutely ill should be visited by the physician as often as necessary. All other patients confined to bed should be seen by the physician at least once daily. Ambulant patients should be seen at least once weekly by the physician and daily by the nurse in charge.

5. Temperature, pulse, and respiration of bed patients should be taken at least twice each day; of ambulatory patients at least once each day.

6. Patients should be weighed once every two weeks unless contraindicated.

7. Treatment of all kinds, general and special, including regulations of physical activities of patients, should be prescribed and supervised by physicians.

8. Since rest is the basic treatment of tuberculosis, strict bed-rest should be available for all patients who need it, and definite periods of enforced rest for all others should be a part of the sanatorium routine. The amount and degree of rest should be prescribed for each patient in detail with all permitted activities and restrictions definitely specified.

9. Facilities should be available for all approved collapse therapy procedures in order that the particular treatment best adapted to a given case may be chosen freely and instituted promptly.

10. All patients receiving pneumothorax should be fluoroscoped before each refill as adequate roentgenological guidance is essential to successful and safe management.

11. Adequate dental service should be furnished at the sanatorium.

12. The medical records of patients should include the following: Admission history, social and medical history, results of physical examinations, X-ray and fluoroscopy interpretations,

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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

laboratory findings, treatments given, reports of consultations and staff meetings, progress notes, surgical and anesthetic data, diagnosis, results of postmortem examinations, and the condition on admisison and discharge. All entries should be dated and signed by the physician concerned. Progress notes regarding the patient's condition should be made at sufficiently frequent intervals to record significant changes in his clinical course and at the time of each examination.

13. The clinical classification of patients on admission and discharge should be made in accordance with the Diagnostic Standards of the National Tuberculosis Association.

Regulation 65. (The Care of Children).

Children with clinically active tuberculosis should be treated in a separate building or in a separate ward of the building for adults.

Regulation 66. (Laboratory Procedures).

1. A complete microscopic blood examination of each patient should be made as soon as practicable after admission. Hemoglobin estimations, red cell sedimentation tests, and a recognized test for syphilis should also be performed.

2. Examination of sputum for the presence of tubercle bacilli should be made in accordance with methods recommended in the Approved Minimum Standards of Laboratory Technique as prepared by the American Trudeau Society Committee on Evaluation of Laboratory Procedures.

3. All patients in whose sputum or discharges tubercule bacilli have not been found should be tuberculin tested by the intracutaneous method.

4. A clinical and microscopic examination of the urine of newly admitted patients should be made to note specific gravity, sugar, albumin, blood and pus cells, casts, bacteria, etc. If any of these tests are positive, further studies should be made as indicated.

5. Pleural exudates and pericardial of pleural effusions, pus from ears, cold abscesses or sinuses, feces, spinal fluid, gastric washings, and biopsy specimens should be examined for tubercle bacilli when indicated.

Regulation 67. (Nursing Service).

1. The director of nursing, assistant director of nursing, supervisors, and head nurses should be registered in the State of Ohio, and preferably should have had special instruction and experience in tuberculosis nursing.

2. Provision should be made for new members of the general duty nursing staff who have not had instruction and experience in tuberculosis nursing to receive at least a short technical course with follow-up supervision.

3. Standard isolation technique should be used and adequate equipment for this purpose should be provided. Nursing service should be properly adjusted with respect to the proportion of infirmary, semi-ambulant, and ambulant patients, the ratio of nurses for whom should be not less than 1:3, 1:8, and 1:30 respectively. This is for 24-hour coverage. If thoracic surgery is done at the institution, the ratio of nurses to patients recently operated upon should be not less than 1:2. In calculating ratios of nurses to patients, suitable credit may be given for services performed by orderlies, nursing attendants, or other well-trained auxiliary workers.

Regulation 68. (Health Supervision of Nurses and Other Employees).

1. All nurses and other employees shall have at the time of employment, an initial complete physical examination which shall include a tuberculin test, chest X-ray examination, a recognized test for syphilis and appropriate laboratory studies.

2. Nurses and other employees who are in contact with patients, patient's rooms, laboratories or fomites shall be X-rayed every three months. This interval may be extended to six months in the case of tuberculin-positive nurses and employees who are past the age of 30. Those who are tuberculin-negative should be retested and X-rayed every three months.

3. Those employees who do not have contact with patient's room, laboratories or fomites shall be X-rayed every six months; if tuberculin-negative, they should be retreated every six months.

Physicians desiring a copy of the amended code may obtain one by writing to Dr. Mark W. Garry, chief, Division of Tuberculosis, Ohio Department of Health, Columbus.

Savage Heads National Foundation

Joe W. Savage, formerly of Charleston, W. Va., has been appointed executive director of the National Foundation for Infantile Paralysis. Mr. Savage, a veteran of both World Wars, was recently discharged from the Army Air Force with the rank of major, after serving three and one-half years. Prior to entering World War II, he was executive secretary of the West Virginia State Medical Association.

State Board Exams March 19-22

The next Ohio State Medical Board Examinations will be conducted at Columbus March 19, 20, 21, and 22.

The Board has revoked the license to practice medicine and surgery of Erich Otten, M.D., Akron, following his conviction of a felony in violation of State and Federal narcotic laws.

The Midwest Physical Education Association Conference will be held at the Deshler-Wallick Hotel, Columbus, March 20-23. The theme of the meeting is: "An American Program in Health, Physical Education, and Recreation".

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Activities of County Societies

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

BUTLER

Officers of the Butler County Medical Society for 1946 are: Dr. Walter Roehll, Middletown, pres.; Dr. Neil Millikin, Hamilton, pres.-elect; Dr. M. W. Gardiner, Middletown, secy-treas.; Dr. C. T. Atkinson, Middletown, delegate; Dr. Harry Lowell, Hamilton, alternate.

CLINTON

Members of the Clinton County Medical Society at a meeting held February 5 voted to establish a Woman's Auxiliary organization. Dr. Reyburn McClellan spoke on the subject, "Hospital Administration", and other topics discussed were a county hospital and cooperation with the Rural Policy Group. Dr. Henry T. Lapp and Dr. Richard R. Buchanan were admitted to membership. A committee on Medical Service to Veterans was appointed.—R. W. DeCrow, M.D., Secy.

HAMILTON

"The Relationship of Pediatrics and Psychiatry" and "Opportunities for Psychotherapy in Pediatric Practice" were the topics of two lectures by Dr. Milton J. E. Senn, assistant professor of pediatrics and psychiatry, Cornell Medical College, New York City, February 5 and 6, before the Academy of Medicine of Cincinnati. These lectures, held in the Auditorium of the Children's Hospital Clinic and Research Building, Cincinnati, marked the 14th annual series of the B. K. Rachford lectureships, under the auspices of the Department of Pediatrics, College of Medicine, University of Cincinnati.

On February 19, Dr. E. H. Botterell, Lt. Col., R.C.A.M.C., University of Toronto, Toronto, Canada, spoke on "Neurological Aspects of Paraplegia".—Bulletin.

HIGHLAND

Dr. Walter Felson, Greenfield, a captain in the Army Medical Corps during World War II, addressed the January 9 meeting of the Highland County Medical Society on the subject, "Personal Experiences in the Medical Phase of Warfare".

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

DARKE

Dr. Lynne Baker, Dayton, addressed the February 19 dinner meeting of the Darke County Medical Society on the subject, "Diagnosis of Chest Pathology with Special Emphasis on X-Ray Findings". The dinner was held at Wayne Hospital.—W. D. Bishop, M.D., secy.

MIAMI

The motion picture, "Managing Fresh Wounds of Violence", was shown by Dr. W. A. Altemeier, professor of surgery, University of Cincinnati College of Medicine, Cincinnati, at the February 1 meeting of the Miami County Medical Society, held in the Stouder Memorial Hospital, Troy. The picture was made under the auspices of Dr. Altemeier and is dedicated to the late Dr. Mont R. Reid.—News clipping.

MONTGOMERY

The Montgomery County Medical Society has employed as field secretary W. H. Means, manager of the county's Medical Service and Medical Business bureaus, according to Dr. N. E. Leyda, society president. Means will attend committee meetings with or in behalf of medical society members unable to attend. He also will contact organizations interested in health questions and which desire the cooperation of the medical society. Mrs. Marie T. Yoder continues as the executive secretary of the organization.—News clipping.

At the February 6 meeting of the society, Dr. Eugene B. Ferris, Jr., associate professor, department of internal medicine, University of Cincinnati College of Medicine, and assistant director of medical service at Cincinnati General Hospital, discussed the subject "Syncope" and its causes. The meeting was held at the Good Samaritan Hospital.—N. E. Leyda, M.D., Pres.

Third District

(COUNCILOR: GUY E. NOBLE, M.D., ST. MARYS)

ALLEN

A dinner meeting at the Lost Creek Country Club was held by the Academy of Medicine of Lima and Allen County January 31 in honor of physicians returning from the service. Carl Herbold, president of the Allen County Tuberculosis Association, discussed mass chest surveys.—H. H. Brueckner, M.D., Secy.

HANCOCK

The following Findlay physicians are officers of the Hancock County Medical Society for 1946: Dr. R. S. Rilling, pres. and alternate; Dr. L. H. Goodman, vice-pres.; Dr. Lena S. Enright, secy.; Dr. F. M. Wisely, treas. and delegate.

HARDIN

Sisters of San Antonio Hospital entertained 22 members of the Hardin County Medical Society at the annual staff dinner January 17.—News clipping.

MARION

The following physicians are the 1946 officers of the Marion County Medical Society: Dr. Richard L. Morgan, Marion, pres. and alternate;

LAST CALL FOR 1946 MEMBERSHIP DUES!

THIS is the last issue of The Journal which will be mailed to former members who have neglected to remit their 1946 State Association membership dues.

Those who desire to continue their affiliation with the State Association should pay 1946 dues immediately to the SECRETARY-TREASURER OF THEIR COUNTY MEDICAL SOCIETY.

As soon as the local Secretary-Treasurer forwards a member's dues to the Columbus office, his name will be restored to the membership roster and mailing of The Journal to him will be resumed.

This action is in accord with Postal Regulations governing The Journal and with the Constitution and By-Laws of the State Association.

Obviously, it does not apply to members still in Military Service or to those leaving the service after December 31, 1945, who have not as yet been able to resume their practice.

Dr. Milton F. Axthelm, Caledonia, pres.-elect; Dr. A. E. Morrison, Marion, secy.-treas.; Dr. J. A. McNamara, Marion, delegate.

WYANDOT

Officers of the Wyandot County Medical Society for 1946 include: Dr. R. J. Semons, Carey, pres.; Dr. F. M. Kenan, Upper Sandusky, pres.-elect; Dr. C. B. Schoolfield, Upper Sandusky, secy.-treas.; Dr. J. Craig Bowman, Upper Sandusky, delegate.

Fourth District

(COUNCILOR: A. A. BRINDLEY, M.D., TOLEDO)

LUCAS

At the February 1 general meeting of the Academy of Medicine of Toledo and Lucas County, held in the Academy Building, the topic "Anesthesia" was discussed by Dr. F. W. Clement, Dr. K. C. McCarthy, and Dr. A. J. Kuehn, all of Toledo.

Feb. 8—Section of Pathology, Experimental Medicine and Bacteriology. "Relationship of the Hospital to the Medical Staff": Norman Losh, superintendent of Riverside Hospital, Toledo, discussed Business Administration; Miss A. E. Mooth, acting director of nursing, Toledo Hospital, discussed the nursing aspect of the subject, and Wilson Benfer, superintendent of the Toledo Hospital, spoke on the Future of the Voluntary Hospital.

Feb. 15—Medical Section. "When, Why, and How Should Carcinoma of the Breast be Treated by Radiation", Dr. Ursus V. Portmann, Cleveland.

Feb. 22—Surgical Section. "Late Complications of Gastric Resection for Ulcer", Dr. Walter L. Bryant, Toledo.

The joint Academy-Auxiliary Dinner was held at the Commodore Perry Hotel February 28.—Bulletin.

SANDUSKY

The following are officers of the Sandusky County Medical Society for 1946: Dr. A. F. Schultz, Fremont, pres.; Dr. J. W. Agnew, Gibsonburg, pres.-elect; Dr. R. C. Fox, Green Springs, secy.-treas.; Dr. J. L. Curtin, Fremont, delegate; Dr. E. C. Swint, Fremont, alternate.

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

ASHTABULA

Dr. Russell P. Rizzo, surgical resident at St. John's hospital, Cleveland, presented a paper entitled, "Diseases of the Gall Bladder and Common Duct—Diagnosis and Management", before the January 8 meeting of the Ashtabula County Medical Society. Nine cases were presented in connection with the paper. The meeting was held at the Hotel Ashtabula.—News clipping.

CUYAHOGA

The Academy of Medicine of Cleveland sponsored the following activities during the month of February:

Feb. 1—Clinical and Pathological Section, at City Hospital. "Friedreich's Syndrome—Familial Demonstration", Drs. Joseph M. DeNardi and Harry Lipson; "Orchiectomy in Cancer of the Prostrate", Dr. Harold McDonald; "An Interesting Case of Renal Disease", Dr. Edward M. Chester; "Case of Scleroderma", Dr. Robert M. Stecher; "Ankylosing Spondylitis", Dr. Walter M. Solomon; "Cysts of Maxilla and Mandible", Dr. P. J. Aufderheide, D.D.S.; "Resection of the Esophagus", Dr. Paul W. Gebauer; "Sprengel's Deformity", Dr. William C. McCally; "Meningitis Caused by More Than One Organism", Dr. John A. Toomey; "Mediastinal Emphysema", Dr. Herbert Z. Lund; "Surgical Case", Dr. J. H.

Lazzari; "Hemangioasarcoma of the Breast with Metastases to the Spine", Dr. Harry Hauser.

Feb. 8—Combined Meeting, Experimental Medicine Section of the Academy and Cleveland Section of the Society for Experimental Biology and Medicine, at the Institute of Pathology Amphitheater. "The Relation of Urea Nitrogen to Non-Protein Nitrogen in Retention", Dr. R. Dominguez and E. Pomerene, Ph.D., department of pathology, St. Luke's Hospital, and Elinor B. Zorn, B.S., department of biochemistry, Western Reserve University; "Further Studies on Renal Hyperlipemia", Dr. Walter Heymann, department of pediatrics, Western Reserve University; "The Nature of the Renal Tubular Mechanism for Acidifying the Urine", Dr. Robert F. Pitts, department of physiology, Cornell University Medical College, and Robert S. Alexander, Ph.D., department of physiology, Western Reserve University; "The Production of Experimental Crush Syndrome", Drs. A. C. Corcoran and Irvine H. Page, Cleveland Clinic Hospital.

Feb. 13—Internal Medicine Section, at Medical Library Auditorium. "Gastrocolic Fistula—An Experimental Study", Drs. R. John F. Renshaw and Robert M. Kiskaddon; "The Exophthalmos of Graves' Disease", Dr. E. Perry McCullagh.

Feb. 15—Downtown Academy Meeting, at the Hotel Cleveland. "The Surgical Pathology of Cholecystitis", Dr. Nathan A. Womack, associate professor of surgery, Washington University School of Medicine, and associate surgeon to the Barnes Hospital and affiliated institutions in St. Louis.—Bulletin.

LAKE

The following Painesville physicians have been elected as officers of the Lake County Medical Society for 1946: Dr. J. M. York, pres.; Dr. W. H. Willis, pres.-elect; Dr. Violet Halfpenny, secy.-treas.; Dr. M. G. Carmody, delegate; Dr. G. R. Smith, alternate.

Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

COLUMBIANA

The following physicians are the Columbiana County Medical Society officers for 1946: Dr. P. H. Beaver, Leetonia, pres.; Dr. A. J. Knapp, East Liverpool, pres.-elect; Dr. R. T. Holzbach, Salem, secy.-treas.

MAHONING

Dr. Richard H. Lyons, from the University of Michigan, Ann Arbor, will address the March meeting of the Mahoning County Medical Society on the subject, "The Management of Edema". The meeting will be held at the Youngstown Club.

At the annual banquet of the society, February 19, at the Youngstown Country Club, A. K. Rowswell, author and humorist, spoke on the subject, "Laughing at the Clouds".—Bulletin.

PORTAGE

Dr. John Holloway, assistant professor of surgery, Western Reserve Medical School, spoke on "Thyroid Disease" at the February 7 meeting of the Portage County Medical Society, held at Robinson Memorial Hospital, Ravenna.—E. J. Widdecombe, M.D., secy.

The 1946 officers of the society are: Dr. Myron S. Owen, Ravenna, pres. and delegate; Dr. Myron W. Thomas, Garrettsville, pres.-elect and alternate; Dr. E. J. Widdecombe, Kent, secy.-treas.

SUMMIT

Dr. Clarence H. Heyman, assistant professor of orthopedic surgery, Western Reserve University Medical School, spoke on the subject "Low Back Pain" at the February 5 meeting of the Summit County Medical Society, held at Nurses' Home, City Hospital.—Bulletin.

TRUMBULL

The subject "Tropical Diseases", was discussed by Lt. Col. B. A. Cockrell, Dr. R. H. Markwith, and Dr. Norman Friedman at the monthly meeting of the Trumbull County Medical Society held at Warren, January 17.

Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

HARRISON

New officers for the Harrison County Medical Society are: Dr. Carl F. Goll, Hopedale, pres. and delegate; Dr. Dwight C. Pettay, Cadiz, vice-pres.; Dr. Richard W. Weiser, secy.-treas. and alternate.

Eighth District

(COUNCILOR: GEORGE F. SWAN, M.D., CAMBRIDGE)

FAIRFIELD

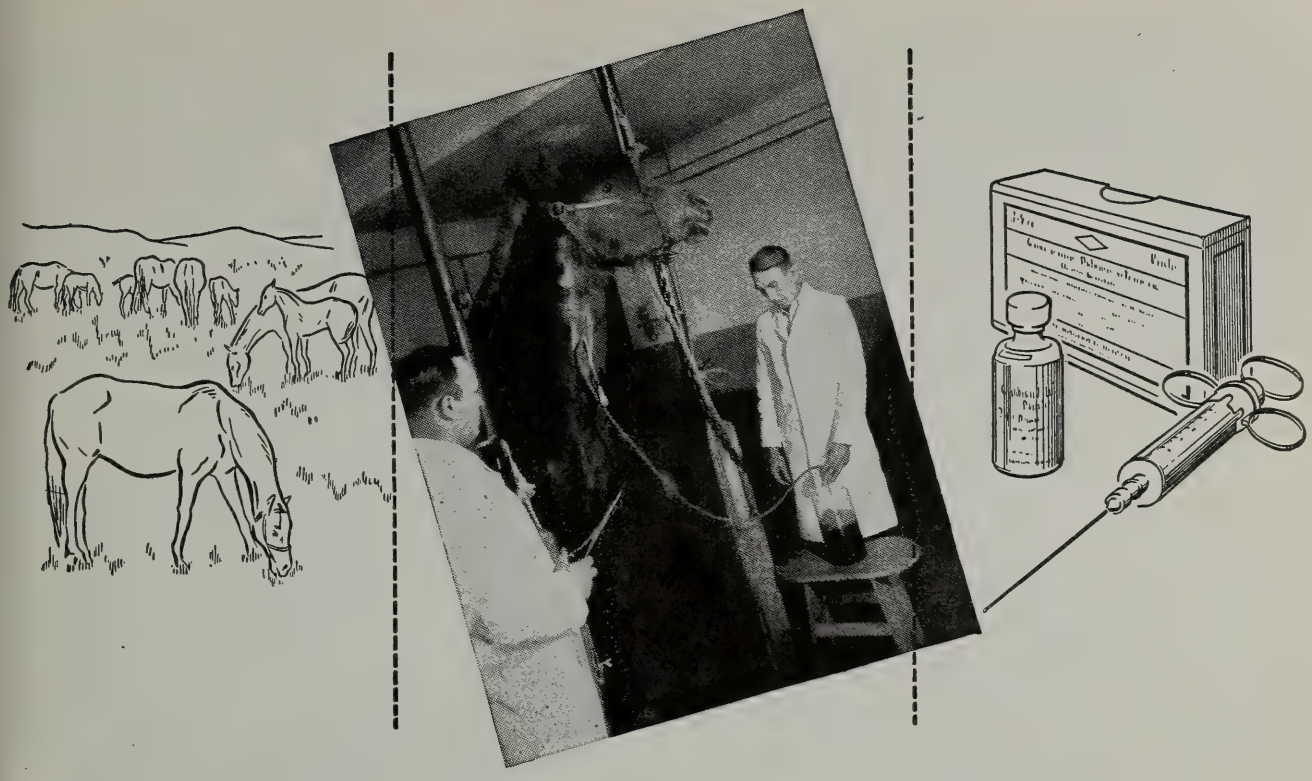
Officers of the Fairfield County Medical Society for 1946 are: Dr. S. C. Sneeringer, Baltimore, pres.; Dr. George Gardner, Lancaster, pres.-elect; Dr. C. W. Brown, Lancaster, secy.-treas.; Dr. C. P. Swett, Lancaster, delegate; Dr. Leo Stenger, Lancaster, alternate.

GUERNSEY

Dr. G. F. Swan, Cambridge, spoke on "Medical Economics" at the January 3 meeting of the Guernsey County Medical Society. At the January 17 meeting, Dr. Earl E. Conaway, Cambridge, discussed "Tropical Diseases", telling of the cases and cures he encountered while serving as a flight surgeon in the air forces in the South Pacific.—Dr. M. S. Lawrence, Secy.

MUSKINGUM

Colonel Peter Rizzo, chief orthopedic surgeon at Fletcher General Hospital, Cambridge, spoke on the subject "The Back" at the Feb-



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ruary 6 meeting of the Muskingum County Academy of Medicine, held at the University Club, Zanesville.—News clipping.

TUSCARAWAS

The Tuscarawas County Medical Society met at the Elks Club, Dover, for their February 13 program. Medical movies and a discussion of tuberculosis, tuberculosis X-rays, and bacteriology, were some of the highlights to the evening.—C. J. Miller, M.D., secy.

Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

HOCKING

The following physicians are officers of the Hocking County Medical Society for 1946: Dr. H. G. Southard, Logan, pres.; Dr. J. W. Doering, Logan, vice-pres.; Dr. Owen F. Yaw, Logan, secy.-treas.; Dr. Charles F. Shonk, Logan, delegate; Dr. C. T. Grattidge, Laurelville, alternate.

LAWRENCE

The annual dinner meeting of the Lawrence County Medical Society was held January 23 at the Elks dining room in Ironton. Appointments of physicians to handle emergency and charity cases at the Lawrence County General Hospital were made on a monthly basis and the hospital staff reorganized.—News clipping.

These Ironton physicians are officers of the Lawrence County Medical Society for 1946: Dr. George G. Hunter, pres. and delegate; Dr. V. V. Smith, pres.-elect; Dr. William A. French, secy.-treas.; Dr. H. W. Johnson, alternate.

Tenth District

(COUNCILOR: GEORGE T. HARDING, M.D., COLUMBUS)

FRANKLIN

Dr. Harrison Evans, Worthington, presented "A Discussion of Neuroses in Returnees" at the February 4 meeting of the Columbus Academy of Medicine held at the Art Gallery in Columbus. Dr. Evans reviewed the more common types of neuroses and suggested techniques for guiding individuals so affected toward a normal life. The discussant for this program was Dr. Nicholas Michael, Columbus. Both physicians were directors of large psychiatric services in the army.

At the February 18 meeting, also at the Art Gallery, Dr. John Adcock, department of medicine, University of Michigan, discussed, "Streptomycin—Therapeutic Applications and Pharmacological Properties".—Bulletin.

FAYETTE

Officers of the Fayette County Medical Association for 1946 are: Dr. E. H. McDonald, Washington C. H., president; Dr. Orlyn Wiseman, Jeffersonville, secy.; Dr. J. H. Persinger, Washington C. H., delegate; Dr. A. D. Woodmansee, Washington C. H., alternate.

PICKAWAY

At a recent meeting of the Pickaway County Medical Society, the members passed a resolution which paid tribute to the late Howard E. Jones, M.D., of Circleville, who died December 12 at the age of 92. He had practiced medicine for 69 years.—News clipping.

Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

LORAIN

Dr. Edward P. McNamee, pres.-elect of the Ohio State Medical Association, addressed the regular monthly meeting of the Lorain County Medical Society February 12 at Castle-on-the-Lake, Lorain, Ohio. The subject of Dr. McNamee's address was "Ohio Medical Indemnity, Inc."—Dr. L. H. Trufant, Secy.

WOMAN'S AUXILIARY NEWS

(BY MRS. FRED W. BROSIUS, MIDDLETOWN)
Chairman, Publicity Committee

CUYAHOGA

The Woman's Auxiliary to the Academy of Medicine of Cleveland recently elected the following officers for the ensuing year: Mrs. Farrell T. Gallagher, pres.; Mrs. C. A. Swan, vice-pres.; Mrs. D. M. Keating, secy-treas., and Mrs. Alexander T. Bunts, publicity chairman. At the February 11 meeting of the St. John's Hospital Guild, Mrs. I. W. Stickney, legislative chairman of the auxiliary, conducted a forum on socialized medicine, and Mrs. Farrell briefly outlined the proposed Wagner-Murray-Dingell bill and explained why it is opposed by the medical profession.

FRANKLIN

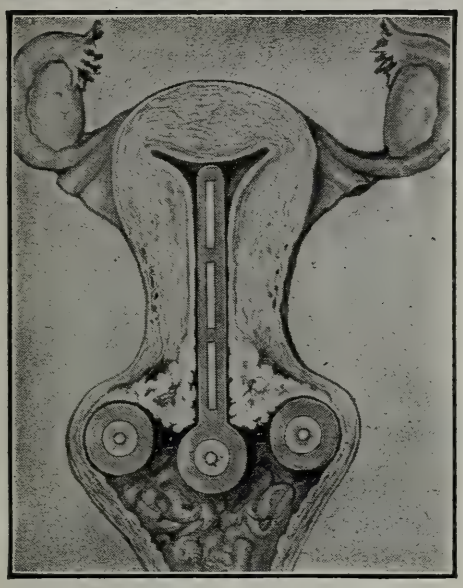
The Woman's Auxiliary to the Columbus Academy of Medicine met January 21 in Mees Hall at Capital University, Columbus, for a musical program by the University's Chapel Choir, directed by Prof. Ellis Emmanuel Snyder. Mrs. Tom Lewis was in charge of the program, which was followed by a business meeting and tea.

From February 1 through 10 the auxiliary collected medical samples from local doctors for use in Poland and other war-stricken areas. The auxiliary met February 18 at the home of Mrs. John Bolton in Columbus for a dessert luncheon. Speaker of the evening was Dr. Charles A. Doan, dean of the Ohio State University College of Medicine, and his topic, "Plasma, the Sulfas, and Penicillin", Mrs. John M. Thomas was in charge of the program.

HAMILTON

The Woman's Auxiliary to the Cincinnati Academy of Medicine will hold a general meeting and tea at the home of Mrs. David Heusinkveld, Cincinnati at 3 p.m. March 12. Charles H.

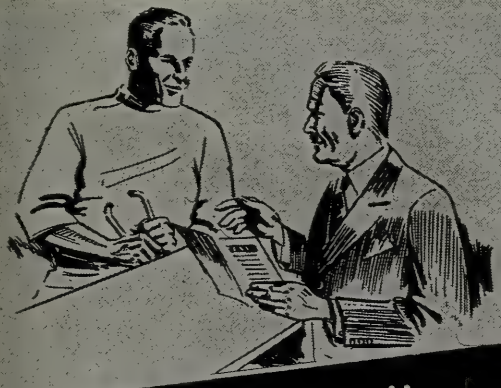
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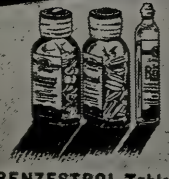
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Coghlan, executive vice-president of Ohio Medical Indemnity, Inc., as guest speaker, will discuss "The Doctors' Plan".

On April 26 a dessert luncheon and card party will be held at the home of Mrs. Gerald Castle, president of the auxiliary.

At a recent business meeting, Mrs. Parke Smith announced that her committee has been collecting drugs for European relief, the last day of the project being March 1. Another committee has been working on the infantile paralysis drive. An open house, held New Year's Day at the home of Mrs. Ashton Welsh was so successful that it was decided to make it an annual affair. Mrs. Cyrella E. Carmel is publicity chairman of the auxiliary.

LUCAS

The Woman's Auxiliary to the Toledo Academy of Medicine met at the home of Mrs. Donald Mebane in Toledo. Mrs. Opal Mundy, Toledo, member of the auxiliary and of the Ohio General Assembly, spoke on the subject, "Proposed Health Plans". Members of the board met February 6 to formulate plans for the academy-auxiliary dinner, which was held on February 28 with Grove Patterson, editor of the Toledo Blade, as guest speaker. Mrs. A. W. Hemphill, chairman of the auxiliary's library committee, recently arranged for members to serve three days a week at the academy library.

MAHONING

The Mahoning County Medical Society Woman's Auxiliary honored the wives of doctors who have returned to the service, and new members of the organization at a bridge tea, held at the Women's City Club, Youngstown, on February 18. A brief business session was held in connection with the meeting.

MARION

At a luncheon of the Woman's Auxiliary to the Marion County Academy of medicine, held recently at the Hotel Harding in Marion, officers for the ensuing year were elected as follows: Mrs. Clair Smith, pres.; Mrs. Richard Morgan, vice-pres.; Mrs. Jack F. Smythe, secy.; Mrs. Clarence Weber, corresponding secy.; Mrs. A. E. Morrison, treas. Mrs. Carl Sawyer presided at the meeting and Mrs. J. W. Jolley was hostess. Guest speaker was Frederick T. Merchant, M.D., who discussed "Education for Peace". Mrs. E. W. Imbody was welcomed as a new member.

ROSS

Fourteen members and three guests were present at the February meeting of the Woman's Auxiliary to the Ross County Academy of Medicine. Dinner at Allyn's Restaurant, Chillicothe, was followed by a meeting at the home of Mrs. Ralph Holmes. Mrs. Loy E. Hoyt presided at the business session.

Mrs. Harold Crumley was appointed delegate to the State Convention in May. Mrs. Hoyt will be the other delegate and Mrs. E. H. Artman, alternate. Guest speaker was Miss Mae Landrum, an army nurse, who served with the 25th General Hospital Unit, of Cincinnati. Miss Landrum delighted her audience with interesting experiences encountered in England, France, Belgium, and Germany. Photographs taken overseas were shown in connection with the talk.

SUMMIT

Newest project of the Woman's Auxiliary to the Summit County Medical Society concerns the prevention of juvenile delinquency. In this connection, Judge Oscar Hunsicker spoke on "Child Delinquency" at the February 5 meeting of the auxiliary, held at the Idabelle Firestone Nurses' Home. He suggested various ways in which the auxiliary can aid in this problem. In connection with the project, a committee has been appointed as follows: Mrs. R. M. Lemmon, chairman; Mrs. E. W. Grubb; Mrs. J. J. Weber; Mrs. D. M. Traul; and Mrs. Paul A. Davis. Mrs. Davis, pres.-elect of the Auxiliary to the Ohio State Medical Association, has had this type of work in mind for some time. The committee has under consideration at present, work with girls enrolled in a class at one of the schools wherein the pupils of the class are selected by the Court of Dometic Relations. These girls are taught cooking, sewing, nutrition, home-making, and child care.

Another project of the auxiliary has been active opposition to the Wagner-Murray-Dingell bill. Last fall, the organization invited the executive officers of all the women's organizations in the county to a tea, where Ex-Congressman Edmund Rowe discussed the bill. Since then, 55,000 pamphlets against the bill have been published by the auxiliary.

At the January meeting, Mrs. L. A. Witzeman described her work with returning veterans at the University of Akron. Mrs. Witzeman, as associate professor of psychology, aids the veterans in their problems of readjustment. At a recent meeting, Mrs. R. L. Ross, in connection with a talk on gourds, displayed her collection of various objects made from gourds which she has raised.

WASHINGTON

The Woman's Auxiliary to the Washington County Medical Society has elected the following Marietta women as officers for 1946: Mrs. W. S. Hawn, pres.; Mrs. A. F. Weiss, vice-pres.; Mrs. F. E. Eddy, pres.-elect; Mrs. T. R. Mattocks, secy.-treas. Committee chairmen are: Mrs. R. H. Sloan and Mrs. J. A. McCowan, program; Mrs. Eddy, stamps; Mrs. I. J. Johnson, Red Cross; Mrs. J. B. McClure, membership; Mrs. E. W. Hill, Sr., scrapbook; Mrs. McCowan, Hygeia; and Mrs. Mattocks, publicity. The auxiliary has collected and counted sales tax stamps since its organization in 1940, giving the proceeds to the Marietta Memorial Hospital.

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Recent Rulings of Attorney General of Interest to Physicians

Among opinions recently issued by Attorney General Hugh S. Jenkins are several of interest to the medical profession. The syllabi follow:

No. 609—The Public Health Council of the State Department of Health has authority, pursuant to Secs. 1232 et seq., G. C., to adopt regulations establishing maximum allowable concentrations for substances used in industry which are dangerous to public health.

No. 628—The fee of 10 cents for traveling each mile allowed to a coroner by former Sec. 2866, G. C., is a part of the compensation allowed a coroner by such section and a coroner who was in office on the effective date of the repeal of said section, to wit, October 12, 1945, would have a right to receive such fee as a part of his compensation during the remainder of his term of office. County commissioners have authority to permit the coroner to use, in the discharge of his official duties, a motor vehicle purchased by them for their own use, and to supply gasoline and oil therefor. That privilege was not limited to a coroner serving before or one serving after the change in the law regarding his compensation.

No. 629—County commissioners are without authority to appropriate county funds for the use of the board of health of a general health district in paying its operating expenses.

No. 710—(1) An acting coroner in a county having a population of less than four hundred thousand, who was appointed pursuant to Sec. 2829, G. C., prior to its amendment by the 96th General Assembly, effective October 12, 1945, was entitled to receive up to said date the fees allowed coroners by Sec. 2866, G. C., but was not entitled under any circumstances, to the difference between the fees so received and the sum of $150 as provided by Sec. 2866-1, G. C. (2) When a regularly elected and qualified coroner is absent from the county by reason of military service he is entitled to the full compensation provided by law for his office, without deduction of any amount paid to an acting coroner or assistant coroner for services rendered during his absence.

Columbus—Dr. Daniel J. Whitacre, a veteran of World War II, has been appointed a member of the City Council, succeeding the late Col. Alfred Ballin.

Cincinnati—Officers of the Cincinnati Social Hygiene Society are: Dr. Carl Wilzbach, president; Dr. Ann Buntin-Becker, vice-president; Dr. E. W. Mitchell, second vice-president; Alfred S. Brown, treasurer. The newly elected officers, along with Bleecker Marquette, compose the executive committee.

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Buckeye News Notes

Bowling Green—Dr. H. W. Mannhardt, recently returned from service as a commander in the Navy Medical Corps, has been appointed coroner of Wood County.

Cincinnati—New officers of the Cincinnati Obstetrical Society are: Dr. Carroll J. Fairo, president; Dr. Stanley Garber, vice-president; Dr. Joseph Crotty, secretary; and Dr. John Fleming, treasurer. The society was organized in 1875.

Cleveland—Dr. Robert M. Stecher addressed a meeting of the Youngstown Planned Parenthood Association on the subject: "A Strong Family Is the Nation's Greatest Resource".

Columbus—Dr. Nelson C. Dysart has resigned as city health commissioner. He had held the post for 16 years.

Columbus—"Medicine, Past, Present, and Future" was the topic of an address made by Dr. Charles A. Doan, dean, Ohio State University College of Medicine, at a meeting of the Cooperative Club.

Dayton—Members of the staff of St. Elizabeth Hospital recently honored Dr. Frederick J. Driscoll with a dinner and presented him with a wrist watch in recognition of his 25 years of

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ZANESVILLE

service on the hospital staff. He will move soon to Ft. Lauderdale, Fla.

Fremont—Dr. Allen P. Newman, who recently established practice here after three years service as a flight surgeon in the Army Air Forces, has been named coroner of Sandusky County.

Greenville—Dr. Frank F. Tallman, State Commissioner of Mental Diseases, was guest speaker at a meeting of the Rotary Club.

Hamilton—Staff officers of Mercy Hospital include: Dr. H. M. Lowell, chief; Dr. Corliss Keller, vice-chairman; and Dr. Vernon Roden, secretary.

Hanoverton—Now in his 54th year of active practice, Dr. H. J. Pelley was recently honored with a family dinner on his 81st birthday.

Lorain—Formerly a major in the Army Medical Corps, Dr. Thomas Peebles related some of his war experiences in Australia, New Guinea, and the South Pacific, at a meeting of the Exchange Club.

Port Clinton—Magruder Hospital staff has elected the following officers: Dr. William R. Gibson, Oak Harbor, president; Dr. Alfred D. Miessner, Port Clinton, vice-president; Dr. George A. Poe, Port Clinton, secretary and treasurer.

Springfield—Dr. Alfred H. Potter has been re-elected president of the Board of Trustees of the Springfield City Hospital.

Toledo—Hon. Homer A. Ramey, Ninth District Congressman from Ohio, discussed "President Truman's Health Program", at the annual meeting of the staff of Toledo Hospital.

Wooster — Dr. Attillio LaGuardia, assistant commissioner of the State Division of Mental Hygiene, was guest speaker at a meeting of the Wooster Teachers Association.

Youngstown—Dr. James L. Fisher spoke on "History, Organization, and Accomplishments of the American Medical Association," at a meeting of the Mahoning Valley Society of Professional Engineers.

Zanesville—The following staff officers of Bethesda Hospital have been re-elected: Dr. O. I. Dusthimer, president; Dr. A. C. Ormond, vice-president; Dr. H. B. Kaufman, recording secretary; Dr. J. H. Bain, Dr. S. W. Obenour and Dr. J. E. Sharp, members of the executive committee.

Zanesville—"Sidelights of the War" was the topic of an address made by Dr. Curtis Ormond at a meeting of the Rotary Club. He told of many of his experiences while a medical officer in England and Wales.



New Psychiatric Clinic Opened at Western Reserve University

The opening of a new psychiatric clinic at University Hospitals, Western Reserve University, Cleveland, was announced February 5 by Dr. Robert H. Bishop, Jr., director of the hospitals. The clinic will provide treatment for civilians at a nominal fee, and free treatment for service men and their families who are referred there by the American Red Cross.

Establishment of the clinic was made possible by the Greater Cleveland Red Cross chapter. Dr. Douglas D. Bond, former head of psychiatry in the United States air surgeon's office and psychiatric consultant to the Eighth Air Force, has been chosen director.

A native of Philadelphia, Dr. Bond also occupies the newly created chair of psychiatry at Western Reserve University and heads the new departments of psychiatry at University Hospitals and at the school of medicine.

Other physicians on the staff include Dr. John M. Flumerfelt, from Philadelphia, formerly of the neuropsychiatric division of the surgeon general's office and consultant in the army service forces in the Mediterranean; Dr. Edward O. Harper, from Pittsburgh, who was overseas three years as chief of neuropsychiatry of the Lakeside Hospital Unit and later chief of the neuropsychiatric service branch of the McCaw General Hospital, Walla Walla, Washington;

Dr. Daniel W. Badal, a graduate of Western Reserve University School of Medicine, who has had experience at four Boston hospitals; Dr. Neil T. McDermott, Bainbridge, O., former holder of a research fellowship in psychiatry at Harvard University Medical School and affiliate of Western Reserve University since 1937; Dr. Theodore Suratt, who was a psychiatrist with the 44th Infantry in France and Germany, and chief neuropsychiatrist at the regional hospital, Camp Polk, Louisiana.

Other staff members not yet arrived will include Dr. O. E. Raezer, Philadelphia, and Dr. and Mrs. Maurice Katan of Holland. Dr. David Crocker, who spent three years as an army psychiatrist with the Yale University Hospital unit will join the staff as a fellow.

All psychiatrists will have positions in the school of medicine at Western Reserve University as well as at the University Hospitals. Plans provide for the eventual erection of a $450,000 psychiatric building.

Dayton—Dr. H H. Herman was honored with a luncheon by a group of local attorneys on the occasion of his retirement after 49 years of active practice.

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Members of Ohio Staff Attend Conference in Chicago

Medical care plans and aid to returning veterans were the major problems discussed at the Conference of State Secretaries and Editors, held February 8 and 9 at A.M.A. headquarters in Chicago.

J. W. Holloway, Jr., director of the A.M.A. Bureau of Legal Medicine and Legislation, and Dr. Joseph S. Lawrence, of the Washington office of the Council on Medical Service and Public Relations, reviewed the current status of medical legislation at the morning session, February 8.

Following the legislative discussion, Dr. F. S. Crockett, chairman of the A.M.A. Committee on Rural Medical Service, spoke on "Plans for Medical Care in Rural Areas".

During the afternoon session, Dr. George F. Lull, A.M.A. associate general manager, spoke on "Aid for Returning Medical Veterans", with a discussion by Victor Johnson, secretary of the A.M.A. Council on Medical Education and Hospitals, and Robert C. Ayers, director, War Property Distribution of the Federal Security Administration.

In the late afternoon session, Col. James C. Harding of the Veterans' Administration spoke on a "Plan for Furnishing Medical Care to Vettrans", preceding a discussion by Dr. L. Fernald Foster, secretary of the Michigan State Medical Society.

At the morning session February 9, Dr. Morris Fishbein, editor of the *J.A.M.A.*, spoke on "Public Relations of American Medicine", with a discussion by John Hunton, executive secretary of the California Medical Association, and Edward Stegen, National Physicians' Committee for the Extension of Medical Care.

Jay Ketchum, executive vice-president of Michigan Medical Service, discussed "Progress Toward a National Medical Prepayment Plan" with a discussion by Dr. A. W. Adson, member of the Council on Medical Service and Public Relations.

Representing the Ohio State Medical Association at the Conference were Charles S. Nelson, executive secretary; George H. Saville, assistant executive secretary; and Hart F. Page, news editor of *The Journal.*

Columbus—Dr. Edward T. Kirkendall, formerly a colonel in the Army Medical Corps and commanding officer of the 100th Evacuation Hospital, was guest speaker at a meeting of Franklin Post No. 1 of the American Legion.

Dayton—New staff officers of Good Samaritan Hospital include: Dr. A. F. Kuhl, president; Dr. W. S. Powell, vice-president; Dr. Richard Hochwalt, secretary; Dr. R. L. Johnson and Dr. Marion W. Coleman, executive board members.

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Infant and Maternal Death Rates Show Big Decline in 10-Year Period

Both babies and mothers have a far better chance of survival now than 10 years ago, the Children's Bureau, U. S. Department of Labor, announced in releasing findings of a comparative study of the nation's birth record for the decade from 1933 to 1943. The study is the first of its kind ever made, for comparable statistics for a 10-year period everywhere in the country were not available until 1933, Dr. Martha M. Eliot, Associate Chief of the Bureau, explained.

In that short time, the birth rate, which was at an all-time low in 1933, rose 30 per cent. The number of live births rose from 2,000,000 to almost 3,000,000 babies born, and in that same period, the infant mortality rate was reduced almost one-third and the maternal mortality rate was slashed more than one-half.

The infant mortality rate was cut 31 per cent, from 58 to 40 deaths per 1,000 live births. The maternal mortality rate in the same period dropped from 62 to 24 deaths per 10,000 live births, a decline of 61 per cent.

Data for Ohio show that the infant mortality rate for Ohio decreased in the 10-year period from 52.7 to 39.1, a decrease of 25.8 per cent. The maternal death rate in Ohio fell from 60.7 to 22.5, a reduction of 62.9 per cent.

Other facts about the birth rate brought to light in the Children's Bureau are:

Although the actual number of births reached its all-time high for the country in 1943, with 3,000,000 live births—and the number was almost as high in 1944—at no time did the birth rate during 1933 to 1943 reach the high levels of 1915 and 1916 when the rate was 25 per 1,000 population. In 1933, it had reached a low of 17 live births per 1,000. By 1943, the birth rate was 21.5.

Far more babies are being born in hospitals—72 per cent of today's babies as compared with an estimate of 35 per cent ten years ago.

Rural mothers in significant numbers are going to hospitals in the cities to have their babies.

The mothers' chances of survival have probably been greatly bettered through the use of sulfa and other drugs, the increased use of blood transfusion, the trend away from the operative delivery, and better hospital regulations all of which are associated with reducing infection. In 1933 infection was the cause of one out of four maternal deaths. In 1943 less than one out of 10 deaths was so attributed. The number of maternal deaths from toxemia likewise declined greatly.

Better care of the mothers is likewise held responsible for a marked decrease in deaths of babies from prenatal causes, the largest single cause of infant deaths. The greatest proportionate reduction in infant deaths was in those due to dysentery, diarrhea and enteritis, and to epidemic and other communicable diseases.

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Do You Know - - -

The Hempstead Academy of Medicine recently provided a health program for a meeting of the Portsmouth Teachers Association. Speakers were: Dr. Chester H. Allen, "Communicable Diseases and Immunization"; Dr. Claude Everett, "Surgery for Children of Pre-School Age"; Dr. Richard Wagner, "Infant Care"; Dr. W. H. Sisson, "Minor Injuries to Children".

* * *

Marked increases in the number of cases of venereal diseases among 15-to-19 year old boys and girls in Cincinnati were reported February 5 by Roy E. Dickerson, executive secretary of the Cincinnati Social Hygiene Society. Cases of syphilis reported in 1944 showed an increase of 103.8 per cent compared to 1940. A study revealed also an increase of 470.7 per cent in reported cases of gonorrhea among these teenagers in 1944, compared to 1941.

* * *

Robert C. Mautner, 46, of Summit, N. J., for the last 22 years associate medical director of Ciba Pharmaceutical Products, Inc., died Jan. 27 in New York, after an illness of a week. Mr. Mautner was widely known throughout the medical profession for his accomplishments in research.

* * *

The appointment of Lt. Col. Margaret D. Craighill as consultant for the medical care of women veterans, the first position of its kind in the Veterans Administration, has been announced by General Omar N. Bradley. Formerly consultant for women's health and welfare to the Surgeon General of the Army, Col. Craighill will serve with 11 other specialists previously appointed as consultants in medicine and surgery for veterans' hospitals under Brig. Gen. Elliott C. Cutler. Before joining the Army, Col. Craighill, a specialist in surgery and gynecology, was Dean of the Women's Medical College of Pennsylvania.

* * *

Bequests and gifts to the University of Cincinnati College of Medicine totaled $38,655.00 during the period of Oct. 1, 1945, through Jan. 9, 1946.

* * *

Dr. Edward J. McCormick, Toledo, chairman of the Council on Medical Service and Public Relations of the American Medical Association, spoke on "Medical Public Relations" at the Annual County Secretaries Conference of the Michigan State Medical Society, Jan. 20, at Detroit.

* * *

Skulls, premedical society of Cornell University, became the 35th chapter of Alpha Epsilon Delta, national honorary premedical fra-

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ternity, upon its installation as the New York Alpha chapter, Jan. 12. The initiation was conducted by Dr. Hugh E. Setterfield, associate professor of anatomy, Ohio State University College of Medicine, and national president of the fraternity, and Dr. Maurice L. Moore, assistant director of research, Frederick Stearns & Co., national secretary.

* * *

Dr. Donald E. Hale, Butte, Montana, a graduate of the University of Pennsylvania and a former Fellow in the department of anesthesia at the Mayo Clinic, has been appointed anesthesiologist at the Cleveland Clinic. For the past three years, Dr. Hale has been in charge of anesthesia at the U. S. Naval Hospital, Philadelphia.

* * *

Plans to observe National Noise Abatement Week, April 28 to May 4, and to extend noise abatement activities through the post-war planning commissions of all cities in the United States, have been announced by the National Noise Abatement Council, 9 Rockefeller Plaza, New York, 20. The object of the Council is "to promote a national consciousness of the need for noise control".

* * *

According to the U. S. Bureau of the Census, the nation's death rate from tuberculosis declined in 1944 for the eighth consecutive year, reaching a record low of 41.3 deaths per 100,000 populations.

* * *

Bids for construction of two 150-bed cottages at the Ohio Hospital for Epileptics at Gallipolis were twice as high as either the estimates or appropriations made by the State Legislature in the Welfare Department's $23,000,000 expansion program. The bids totaled nearly $1,000,000 for work for which the Legislature appropriated $450,000. No bids at all were received for the construction of a $2,500,000 project at the Apple Creek School for Feeble Minded in Wayne County.

* * *

Approximately 56 per cent of the citizens of the Cleveland area have Blue Cross protection through the Cleveland Hospital Service Association.

* * *

Dr. Elmer L. Sevringhaus, Madison, Wis., has resigned as professor of medicine at the University of Wisconsin Medical School to become director of clinical research for Hoffman La Roche, Inc., with headquarters at Nutley, N. J. During World War II, Dr. Sevringhaus went to Italy on a nutritional project for UNRRA.

* * *

Dr. A. A. Brindley, Toledo, Councilor for the Fourth District of the Ohio State Medical Asso-

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ciation, discussed the Wagner-Murray-Dingell bill at a meeting of the Northwestern Branch of the American Pharmaceutical Society at Toledo.

* * *

Dr. William Muhlberg, medical director of the Union Central Life Insurance Company, Cincinnati, since 1916, and a vice-president since 1929, retired recently. He will be succeeded by Dr. Charles Maertz, assistant medical director. Dr. Muhlberg is president of the Cincinnati Board of Health, a past president of the Public Health Federation and of the Life Insurance Medical Directors of America.

* * *

A native of Paulding and well-known by many Ohioans, Dr. Don W. Gudakunst, White Plains, N. Y., medical director of the National Foundation for Infantile Paralysis for the past six years, died suddenly in Chicago, Jan. 20, aged 51. He was state health commissioner in Michigan for several years.

* * *

Emil H. Schellack, vice president and director of sales of The Upjohn Company, Kalamazoo, Mich., died on Feb. 12. He had been connected with the Upjohn sales organization for over 26 years.

* * *

Dr. Newton W. Larkum, formerly a lieutenant colonel in the Army Medical Corps, has been named medical director of Ames Company, Inc., Elkart, Ind. A graduate of the School of Tropical Medicine, Army Medical School, in 1944, Dr. Larkum was chief of the Division of Bacteriology from Nov. 1941 to 1943 and later was chief of Laboratory Service, 100th General Hospital.

* * *

The International Association of Allergists has been incorporated by officials of the American College of Allergists. It is planned to hold the first international congress in Paris in 1948. The first Pan American Congress to be held under the auspices of the College at its next annual meeting is tentatively set for Oakland, Calif., June 28-30, 1946. Members of the first executive committee, which will compose the temporary group of officers until the first election in 1948, includes Dr. Jonathan Forman, Columbus, and Dr. Karl Figley, Toledo.

The 1946 Assembly of the Interstate Postgraduate Medical Association of North America will be held at the Public Auditorium, Cleveland, October 15 to 18.

* * *

Dr. W. F. Machle, Cincinnati, is a member of the Editorial Board of *Occupational Medicine*, a new magazine being published monthly by the American Medical Association. The annual subscription rate is $6.00.

* * *

Ninety-one out of 100 of the babies born in the United States under the E.M.I.C. program in 1944 were born in hospitals, as compared with 76 out of 100 for all infants in that year, according to the U. S. Children's Bureau.

* * *

The next (eighteenth) edition of the American Medical Directory will not be published until 1947, according to information from the Directory Department of the American Medical Association. Copies of the latest edition, published in 1942, are no longer available.

CLASSIFIED ADVERTISEMENTS

Rates: 50 cents per line, payable in advance. Minimum charge of $1.00 for each insertion. Price covers the cost of remailing answers. Forms close 16th of the month preceding publication.

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The Physician's Bookshelf

Pulmonary Tuberculosis; a Handbook for Students and Practitioners, by R. Y. Keers, M. D., and B. G. Rigden, M. D., ($5.00. *A William Wood Book, The Williams and Wilkins Co., Baltimore*) is a profusely illustrated British manual of excellent quality.

Practical Neurological Diagnosis, by R. Glen Spurling, M. D., ($4.00. 3rd Ed. *Charles C. Thomas, Publ., Springfield, Ill.*) presents a simple account of the principles to be applied in this field. It is an excellent answer to the need that most of us have for a manual of neurologic examinations.

Active Psychotherapy, by Alexander Herzberg, M. D., ($3.50. *Grune & Stratton, Inc., New York City*) describes the author's own method. It is a compound, or rather an intergration, of psychoanalysis, persuasion, exertion of direct influence on the patient's milieu, and tasks given the patient. The main thing is the tasks. We physicians, who are victims of urbanization, have to learn about human nature from books and we shall do well to study this little volume.

Radio in Health Education, prepared under the auspices of the New York Academy of Medicine, ($1.60. *Columbia University Press, New York City*) is a "must" for all who are interested in radio as a tool for health education or for laying a sound foundation for medicine's public relations. Radio is an excellent tool but it must be used with skill else our accidental audience will promptly dial us out.

Back To Life. The Emotional Adjustment of Our Veterans, by Herbert I. Kupper, M.D., ($2.50. *L. B. Fischer Publ. Corp., New York City)* exposes the sources of the returned soldier's irresponsible conduct and so enables his friends to deal with causes instead of symptoms.

Hypoanalysis, by Lewis R. Wolberg, M.D., ($4.00. *Grune & Stratton, Inc., New York City)* presents the account of the hypoanalytical treatment of a patient ill with a severe emotional problem. A fascinating document.

The Extremities, by Daniel P. Quiring, Ph.D., Beatrice A. Boyle, Erna L. Boroush, M.A., and Bernardine Lufkin, A.B., of the Cleveland Clinic, ($2.75. *Lea & Febiger, Philadelphia)* offers a series of diagrams showing the origin, insertion, action, and arterial and nerve supply, together with their motor points. It should be helpful to anyone "looking up the subject".

Public Medical Care, by Franz Goldman, M.D., ($2.75. *Columbia University Press, New York City)* is an attempt to give a composite picture of public medical care as a social movement. Worth your reading.

What the Informed Citizen Needs To Know, edited by Bruce Bliven and A. G. Mezerik, ($3.00. *Duell, Sloan & Pearce, Inc., New York City*) a compilation of the writings of Henry Wallace, Alvin Hausen, Chester Bowles, Leon Henderson, Philip Murray, Senator O'Mahoney, Lester Hill, Elbert Thomas, and Thomas Parran—a New Deal roundtable and a good place to get a summary of the thinking of the opposition.

Hidden Hunger, by Icie G. Macy, Ph.D., and Harold H. Williams, Ph.D., ($3.00. *The Jaques Cattell Press, Lancaster, Pa.)* traces hunger and food selection from the earliest times. The development of nations is explained in terms of the nutrient value of their food supply. It should be read by every American citizen because it deals with one of the basic problems of our civilization, i.e., population and food.

A Future for Preventive Medicine, by Edward J. Stieglitz, M.D., ($1.00. *The Commonwealth Fund, New York City)* is another book in the series "On the Changing Order" sponsored by the New York Academy of Medicine. The author pleads for more than the prevention of disease, he asks for the optional development and betterment of the individual.

Pediatric X-Ray Diagnosis, by John Caffey, M.D., ($12.50. *The Year Book Publ., Inc., Chicago)* is a text for students and practitioners of pediatrics, surgery, and radiology, none of whom can afford to be without it as a book of reference. It covers the subject completely in 825 pages and 709 illustrations that really serve to clarify the text.

Air Commando Doc, by Lt. Col. Robert Collier Page, M.C., A.U.S., ($2.50. *Bernard Ackerman, Inc., New York City)* is the story of the medical unit with "Project 9" and, more, it is the story of a heroic undertaking. You will enjoy it.

Medical Malpractice, by L. J. Regan, M.D., LL.B., ($5.00. *The C. V. Mosby Co., St. Louis, Mo.)* discusses in a helpful manner this most distressing problem.

Glycerin, Its Industrial and Commercial Application, by Georgia Leffingwell, Ph.D., and M. A. Lesser, B.Sc., ($5.00. *Chemical Publ. Co., Inc., Brooklyn, N.Y.)* is a comprehensive survey of the 1,583 uses to which this chemical is put, many of them medical.

Atlas of Surgical Approaches to Bones and Joints, by Toufick Nicola, M.D., ($5.00. *The Macmillan Co., New York City)* is a textbook of original drawings. It confines itself strictly to the subject and therefore is an unusually helpful book of permanent value.

The Ohio State Medical Journal

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Vol. 42 April, 1946 No. 4

JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.*

GEORGE H. SAVILLE, *Asst. Managing Editor*

HART F. PAGE, *News Editor*

Management of Obscure Gastrointestinal Hemorrhage

THOMAS E. JONES, M.D.

MANAGEMENT of severe gastrointestinal hemorrhage from (1) cirrhosis of the liver with esophageal varices, (2) gastric or duodenal ulcer or tumor, (3) ulcerative colitis or malignant neoplasm of the colon, or (4) certain blood dyscrasias, such as hemophilia, thrombocytopenic purpura, of Banti's disease, has been adequately discussed in the literature. Little has appeared, however, on the management of severe intestinal hemorrhage of obscure origin.

CAUSES

In the management of gastrointestinal hemorrhage of known cause, certain measures are of proved value. In hepatic cirrhosis there frequently are esophageal varices, which may give rise to severe hemorrhage. Whereas formerly nothing could be done, now considerable success is obtained by injection of a sclerosing solution into these varices through an esophagoscope. Even though the disease is fatal, one can eliminate for the patient the mortal fear of other hemorrhages.

Ordinarily hemorrhage from a gastric or duodenal ulcer occurs when the patient is under treatment, and accordingly one may readily and correctly suspect the source of the hemorrhage. Occasionally, however, a patient with no previous symptoms may have massive hemorrhage from an acute gastric or duodenal ulcer. However, this is not common. Treatment of this type of hemorrhage unfortunately can not be entirely standardized. Every patient is individual, and treatment depends on age, number of hemorrhages, amount of bleeding, general condition, amount of shock, and so forth.

Submitted on request, November, 1945.

The Author

●Dr. Jones, Cleveland, Ohio, is a graduate of Western Reserve University School of Medicine, 1916; diplomate, American Board of Surgery; fellow, American College of Surgeons, member, American Surgical Assn., and American Assn. of Obstetricians, Gynecologists, and Abdominal Surgeons; and staff member, Cleveland Clinic Hospital.

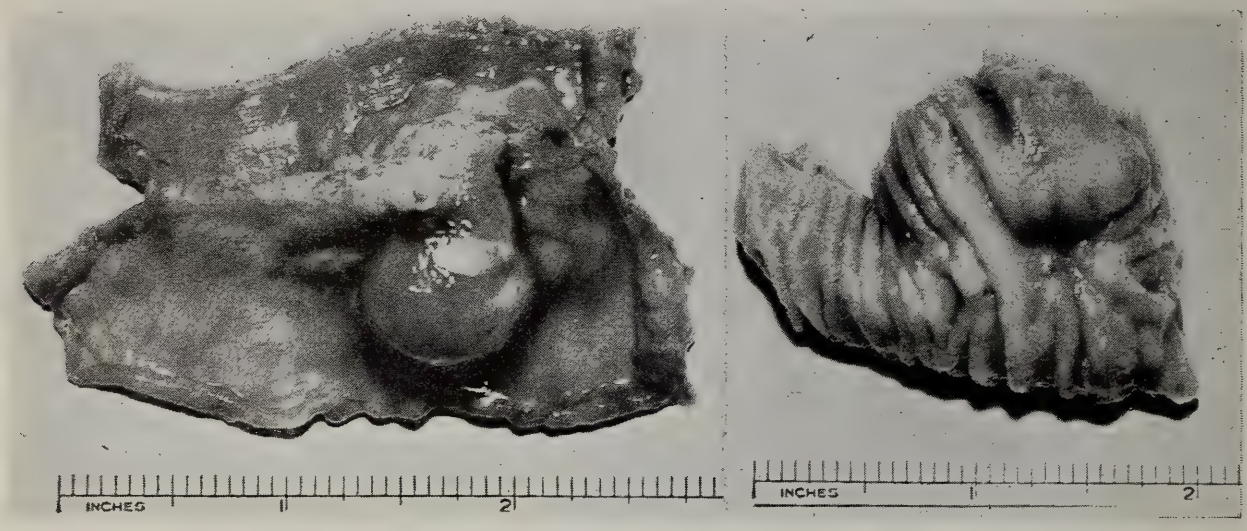
Obviously, the first measure is to combat shock. The foot of the bed is elevated, and morphine may be used to allay apprehension. Because heat causes peripheral vasodilatation its application in shock is now the subject of controversy. The use of cold has been suggested because it causes vasoconstriction and may help to maintain the blood pressure. However, some believe that bleeding will continue if the blood pressure is kept too high.

The blood pressure should be taken every half hour. Some advocate not resorting to transfusion until it reaches 40 mm. of mercury. My practice is to start transfusion, the blood being given very slowly, if the pressure drops below 60. If it drops too low, the mechanism may get out of control and be much harder to manage. No harmful effects should follow transfusion if the blood is given slowly and in quantities not larger than 500 cc. I have not observed that transfusions thus given cause renewed bleeding. All food by mouth is prohibited. Intravenous fluids are given to maintain the water balance.

Age plays a very important role in the man-



Case 1, Fig. A—Resected specimen of ileum. Fig. B—Specimen opened showing difference between gastric and ileac mucosa.



Case 2, Fig. A—Segment of ileum removed. Fig. B—Specimen open showing opening into diverticulum.

agement of hemorrhage. In patients under 45 expectant treatment may suffice. However, patients over 55 with sclerosis of the vessels must be watched more carefully. If the bleeding does not tend to stop, I favor massive transfusions and immediate operation.

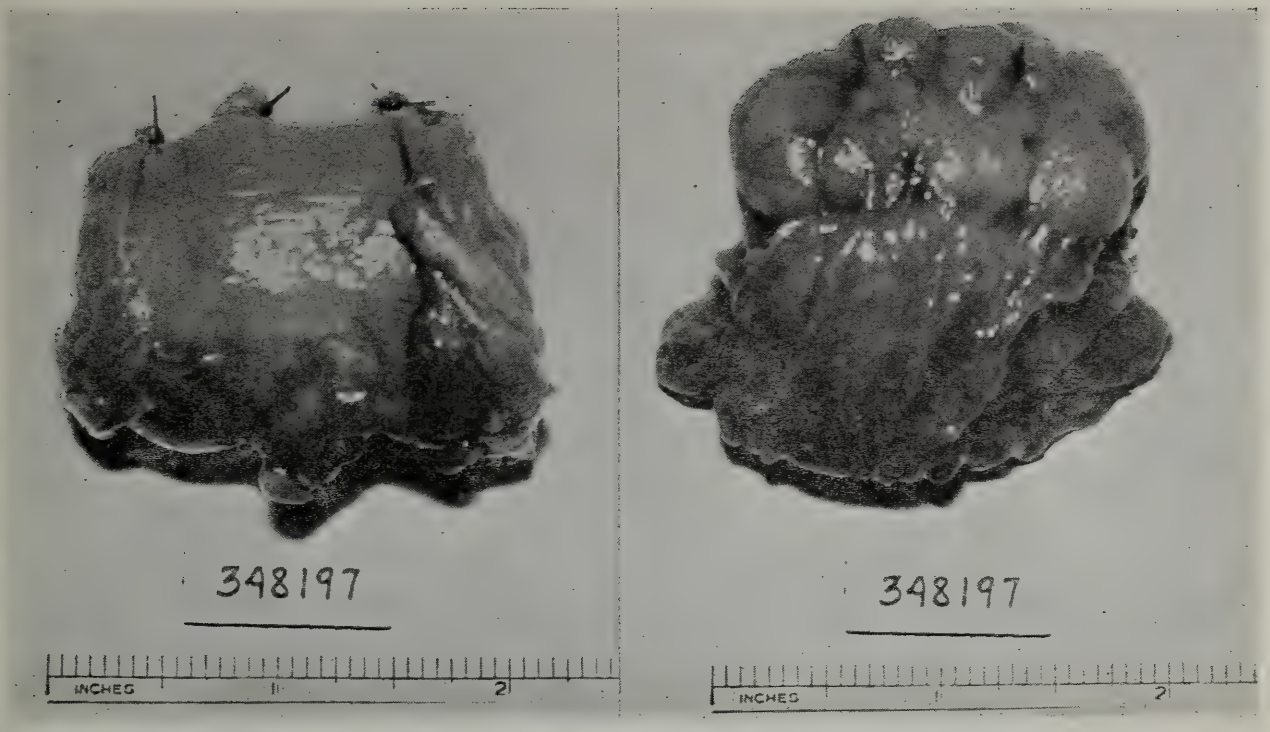
POSTHEMORRHAGE

If the patient recovers with palliative procedures, one is confronted with management in the posthemorrhage phase. In a young patient with the first hemorrhage I am inclined to be conservative, unless severe ulcer symptoms have been present for a long time. Because of the great likelihood that bleeding will recur, resection is advised. In patients over 55 I recommend resection as soon as the patient is rehabilitated. If roentgenograms have not been made previously, roentgen examination may be safely undertaken two weeks after the hemorrhage has been arrested. Many benign tumors in the pylorus and occasionally those in the duodenum may produce ulcer-like symptoms, which have not been severe enough to warrant previous treatment. Any information one can have before operation is valuable.

In previously known and treated regional ileitis and ulcerative colitis large hemorrhages may occur. Even if the preferred treatment is medical, the onset of severe bleeding changes the problem to a surgical one because the bleeding tendency will continue.

Opinion varies widely as to whether diverticulosis of the colon causes bleeding. In my experience bleeding from this cause is practically nil. This observation is further substantiated by the fact that 60 out of every 1,000 routine roentgenograms of the colon show some diverticulosis. Bleeding is probably assigned to this cause because in follow-up examinations diverticulosis is the only finding. Further searching may reveal a coexisting condition.

Bleeding is common in malignant neoplasms of the colon, but a true hemorrhage is rare. Generally the bleeding is readily controlled, and



Case 3, Fig. A—Segment of jejunum removed. Fig. B—Opened specimen of tumor with broad base visualized.

further examination reveals the exact cause. Polyps, single or multiple, may cause similar symptoms.

OBSCURE HEMORRHAGE

The main purpose of this article, however, is to discuss a group of cases in which all known diagnostic methods fail to reveal the cause of hemorrhage. Such obscure hemorrhage usually occurs in a patient who has been in good health. He becomes faint and nauseated, cold and clammy, and has an urge to defecate. Upon inspection the stool is found to consist wholly of bright red or dark blood or a mixture of both. Routine management, as previously outlined, usually causes the bleeding to stop, leaving the patient weak and apprehensive, particularly during the first attack. Operation at this time is not even considered.

After recovery from the hemorrhage a thorough investigation is made. The first examination is the simplest—a sigmoidoscopic examination. If this is negative, roentgen examination of the gastrointestinal tract is made. Frequently the results of all examinations are within normal limits.

It is to the subsequent treatment of these patients that I particularly wish to call attention. I remember sporadic cases in the past, but recent experience with four patients has focused my attention anew on this very important problem. I admit being brought up with the idea that it was useles to explore a patient in whom nothing was found at preliminary examination. This, I believe, was also the general opinion. Perhaps the simplest way to clarify the problem is to relate briefly the management of these four patients, all of whom had a previous diagnosis of "bleeding of unknown origin".

Case 1—A girl, aged 5, was admitted on August 10, 1943. Rectal bleeding, present intermittently since 6 or 7 months of age, would last four or five days and was associated with rectal pain, anorexia, and nausea. Blood passed by rectum was red. There was no abdominal pain or distension. The mother estimated that the child was in a children's hospital two years out of the past five and probably had 30 transfusions. There was a constant fear of hemorrhage. All previous examinations were within normal limits. Everyone hoped that the child would outgrow her trouble.

Examination revealed a pale, fairly well nourished, white girl. There were no positive findings. By proctoscopic examination the rectum was normal for 10 inches. Roentgenograms of the colon were normal on two occasions. Motility studies on small intestine were not done. Hemoglobin was 58 per cent, erythrocyte count 3,280,000, and urea 30 mg. per 100 ml. Special blood study showed no blood dyscrasia to account for the bleeding. In spite or normal findings exploratory operation was advised and was accepted by the parents because of their fear of more hemorrhages.

At operation on August 16, 1943, an anomaly was found 10 to 12 feet proximal to the ileocecal valve. It consisted of a Y-shaped piece of gut and had the appearance of a side to side anastomosis. The area was resected with a side to side anastomosis, open method. Convalescence was uneventful, and the child was discharged on the sixth postoperative day.

Pathologic report showed congenital anomaly of intestine with atopic, atypical duodenal and gastric mucosa and chronic diffuse enteritis. On



Case 4, Fig. A—Segment of ileum removed. Fig. B—Specimen opened showing a deep ulcer.

opening the specimen reduplication with weblike areas across the intestine was seen.

Case 2—A girl, aged 3½, was admitted on May 1, 1944. She was perfectly well during the first year of her life. She then had recurrent attacks of periumbilical pain occurring every one to six weeks, lasting from four to 14 days, and associated with nausea and vomiting. She was always constipated with hard dry stools. One severe intestinal hemorrhage had occurred the past summer. Five days before admission to the clinic her stools were full of blood, some dark and some bright red, but none were tarry.

Examination revealed a poorly nourished child with evidence of exsanguination. The only positive finding was a slightly palpable liver. Proctoscopic examination showed old blood coming down from above.

Roentgen examination revealed a normal gastrointestinal tract. The hemoglobin was 40 per cent, erythrocyte count 2,600,000.

Operation was performed on May 8, 1944, after the parents finally consented to exploration. A mass the size of an English walnut was found in the small intestine, 8 feet proximal to the ileocecal valve. A presumptive diagnosis of Meckel's diverticulum was made, although the lesion was higher than usual. It was resected, and a side to side anastomosis made. The child was discharged on the 11th postoperative day and has been well since.

According to the pathologic report the diverticulum was the seat of focal, partly organized, acute ulcerative inflammation. There was hyperplasia of regional lymph nodes. Ulceration was present in the mucosa lining the diverticulum. Atopic gastric or duodenal tissue was not demonstrable.

Case 3—A man, aged 43, was admitted on May 16, 1944. For 17 yars he had had numerous episodes of bleeding with weakness, faintness, and tarry stools. He had had several X-ray examinations and had been told he had a duodenal ulcer, for which during this period he was treated with various diets. With bed rest and a liquid diet the bleeding would stop. At times of bleeding he had no typical ulcer pain but a "miserable feeling" in the pit of the stomach and he noticed a tender spot in the epigastrium. Food seemed to relieve the distress. The month prior to admission he had three hemorrhages and for the first time saw bright red blood.

Examination showed a fairly normal white man of medium build, with some pallor. The abdomen showed some evidence of muscle guarding and tenderness in the epigastrium. Proctoscopic and gastroscopic examination were normal. Roentgen examination of the gastrointestinal tract was normal. Hemoglobin was 50 per cent, and erythrocyte count 2,860,000. Special blood study showed no bleeding tendency. Protein 5.4. Exploratory operation was advised and gladly accepted.

At operation on June 1, 1944, a reddened mass the size of an English walnut was found in the jejunum, 15 inches distal to the ligament of Treitz. There was considerable puckering of the peritoneum over the lesion in the mesentery.

On section the tumor, which was 2.8 x 2.6 cm., was very firm on cutting. In the thinned-out mucosa over it was an ulceration. which was the site of the hemorrhage. Microscopically it was a leiomyofibroma. He was discharged on the 13th postoperative day and he has had no symptoms since.

Case 4—A man, aged 39, was admitted on April 5, 1944, with the complaint of bleeding from the rectum. He was well until 1941, when he had an attack of rectal bleeding, causing him to faint. Proctoscopic examination was normal. In January, 1944, a more severe bout of bleeding required three transfusions. The blood was dark red. He was hospitalized and recovered. He had no pain or change in bowel habit other than the bleeding. Because his own physician could not find the cause of the bleeding he came to the Clinic.

Physical examination was normal. Sigmodioscopic examination was normal. Roentgen examination of the gastrointestinal tract, including air injection of colon, was negative for polyps. In spite of all normal findings exploratory operation was advised but the patient refused. Five months later, October, 1944, he had another exsanguinating hemorrhage at home and required

three transfusions. Because he did not feel well for the next two months, he returned and asked to have an exploratory operation.

An exploratory laparotomy was performed on December 29, 1944. Large Meckel's diverticulum, which looked like a miniature stomach and was the size of an orange was found 36 inches proximal to the ileocecal valve. The mucosa resembled gastric mucosa and contained a large ulcer, the source of bleeding. Resection of 6 inches of ileum with side to side anastomosis was done. Convalescence was uneventful. The patient was discharged on the 13th postoperative day.

DISCUSSION

Laymen and surgeons are prejudiced because exploration so often fails to reveal the cause of obscure hemorrhage. The answer is simply that the exploratory operation is not thorough. I have observed the manner in which such explorations are done. Believing generally that hemorrhage comes from a gastric or duodenal ulcer, the incisions are usually upper right rectus incisions. The stomach and duodenum are inspected and palpated so much that the pylorus and duodenum became stippled, and the surgeon is prompted to open the stomach or duodenum and look in. This consumes considerable time and the surgeon then concludes that it is an obscure case. To ease his conscience the surgeon then places his hand in the abdomen and feels around for a time and finds nothing. When the patient has subsequent hemorrhages, he naturally seeks another physician. With the history of a previous negative surgical exploration, the surgeon hesitates to recommend, and the patient refuses, another exploration.

If the cause of the bleeding is to be found the gastrointestinal tract must be inspected and palpated every inch of the way. Obviously, this can not be done through an upper right rectus incision. Realizing that the small intestine is the blind spot in roentgen diagnosis, I use the following technic:

A low midline incision is made from the umbilicus to the symphysis. The ileoceccal valve is located, and every inch of the small intestine is visualized and palpated. With this technic the cause of the trouble was found in all reported cases. I am not sure that mere blind palpation would have produced negative results. If the small intestine gives negative results, the colon is then subjected to the same examination. If this is negative, I make an upper midline incision and explore the stomach and duodenum. The examination is made in this order because roentgen examination is effective in diagnosis of stomach and colon lesions but has no value in the small intestine except in cases of obstruction.

I strongly advocate exploratory operation in these cases of bleeding of unknown origin because I feel that most of them can be known. The exploration, however, must be thorough.

KEEPING UP WITH MEDICINE

MASS surveys of chest with X-rays often find, but do not necessarily identify, disease.

* * *

ALL who are concerned with mass X-rays of the chest should be on the alert for possible cancer of the lung.

* * *

VASOCONSTRICTOR drugs as they are issued by the manufacturer are entirely too potent and the addition of "sulpha" drugs and antibiotics makes the post-vasoconstrictor rebound and irritation all the worse. Certainly, in acute rhinitis additional irritation is not needed.

* * *

MORPHINE is the drug of choice in cardiac asthma and is most dangerous in bronchial asthma. It is liable to cause death from acute respiratory failure. Most asthmatics who die, die from the use of morphine and not from the disease.

* * *

BRONCHOSTENOSIS as a complication of bronchial asthma may be suspected in those patients who have a severe but non-productive cough and then suddenly the sputum becomes profuse, mucopurulent, and streaked with blood. This is especially significant if there are recurring episodes of fever with or without chills. Mansmann has emphasized recently in this situation that use of inspiratory and expiratory films together with fluoroscopy is of great aid.

* * *

WITH the exception of nickel, very few cases of contact dermatitis are caused by metals.

* * *

IN many plants the greatest number of unnecessary skin eruptions and the most severe ones are caused by the topical application of the "sulfa" drugs to the skin of workers with lacerations, contusions, and infections. Approximately 15 per cent of those who use "sulfa" in this way will become allergic to it.

* * *

STREPTOMYCIN appears to be a specific for tularemia.

* * *

WHILE a diagnosis of heart disease depends upon an examination of the heart, the prognosis and treatment depend upon the examination of the patient.

* * *

FUMES from cutting or welding galvanized iron are irritating. Poisoning and absorption may occur chiefly from the zinc fumes but in some instances the lead in the iron may develop a concentration sufficient to cause symptoms of lead poisoning. An allergy may be developed toward the zinc.—J.F.

Respiratory Allergy: A Plea for a Basic Nomenclature

JONATHAN ZONIS, M.D.

THE purpose of this paper is to simplify and clarify the nomenclature in the field of allergy, especially that pertaining to the afflictions of the respiratory tract.

The literature on allergy is pregnant with a terminology that is ambiguous and confusing. This confusion should be cleared up since allergy is frequently encountered not only by the general practitioner and internist, but also by the otolaryngologist, occulist, surgeon, neurologist, dermatologist, and other specialists.

The Author

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PRESENT STATUS

In reviewing the many publications and texts on allergy as I am now doing, I find many authors are using different terms to identify one concept (as hypersensitivity, allergy, atopy, idiosyncrasy, etc.); while others are using the same terms to identify opposing concepts. Every textbook on allergy begins with a set of definitions that are unlike those of other textbooks.

John A. Kolmer, for example, in writing the foreword in Tuft's book on "Clinical Allergy", a popular text on the subject, begins with the following statement: "There is probably no subject in clinical medicine and immunology more perplexing to the physicians than that of allergy, or hypersensitiveness, due in large part to the multitude of new terms that have been introduced from time to time as well as various theories and accumulation of a large and confusing literature."

W. T. Vaughan,[2] in his textbook, "Practice of Allergy", states: "It is regrettable that in the development of this new subject each investigator has suggested interpretations of his own coinage. As a consequence we have many words originally intended to signify essentially the same thing. Some have accepted the terms as originally defined while others have adopted them, but given them different significance. Some confusion has resulted."

The following is a list of terms (taken from Urbach and Gottleib)[3] which various authors use to represent one entity: "Vasomotor rhinitis, perennial rhinitis, paroxysmal rhinitis, extrinsic and intrinsic rhinitis, allergic coryza, atopic coryza, contact allergic coryza, paroxysmal rhinorrhea, hydroa nasalis, and allergic rhinopathy". To this list the authors add some of their own.

Similarly, the terms for the allergic conditions of the lower respiratory tract are many and confusing. Some of them are: asthma, bronchial asthma, asthmatic bronchitis, allergic cough, allergic bronchitis, and allergic bronchiectasis. It is obvious, therefore, that a uniform terminology is not only desirable but absolutely essential.

Submitted November 26, 1945.

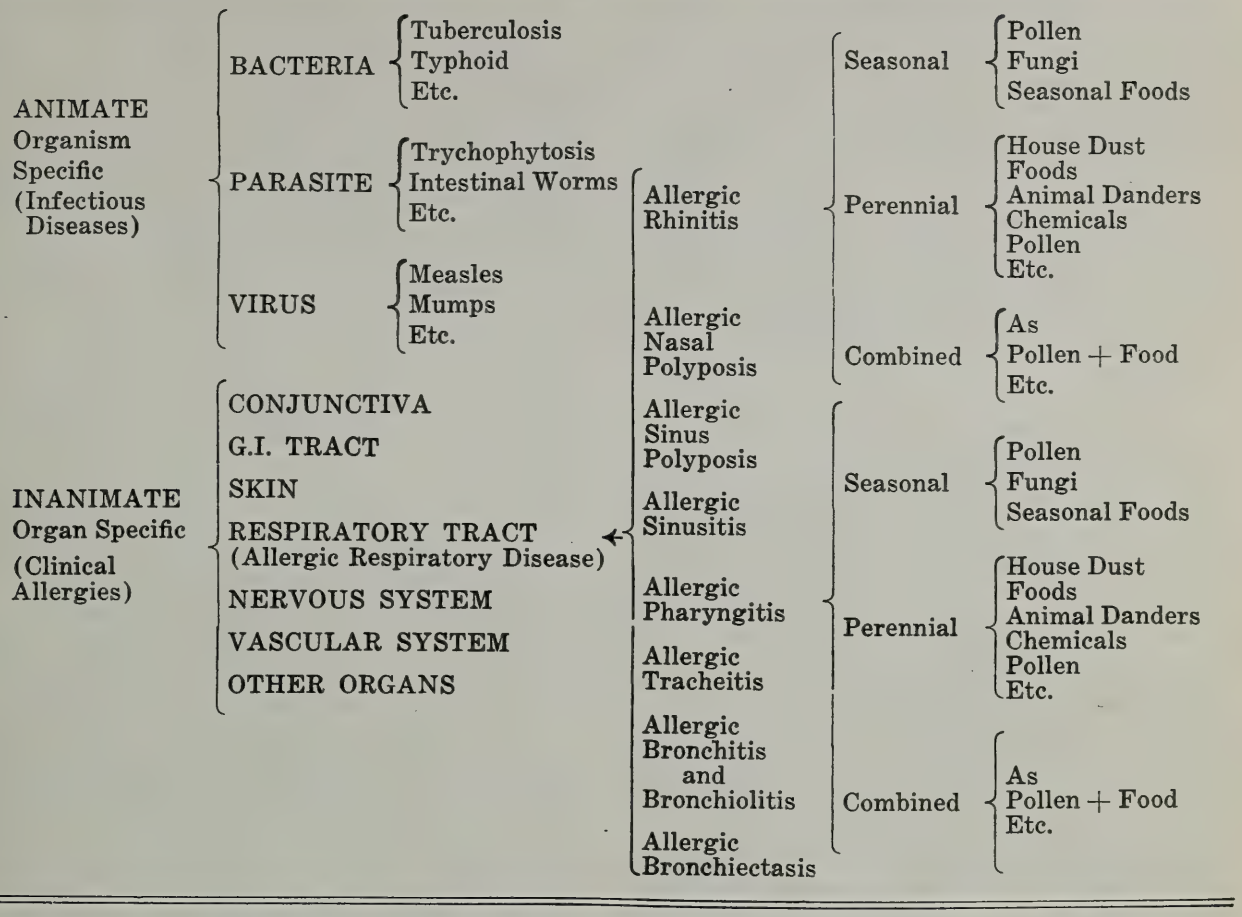
THE PROPOSAL

In order to clarify and unify the nomenclature of the allergic disorders in the respiratory tract as here proposed, the definition of allergy itself should precede any other. William C. Boyd,[4] in his text on "Fundamentals of Immunology", describes clearly the meaning of allergy, not only as originally intended by Von Pirquet, but also as it is understood and used by the majority of fundamental workers in the field at the present time; "Von Pirquet coined the word allergy, meaning literally 'changed or altered reactivity' to denote any acquired specific alteration in the capacity to react, which occurs in living organisms or tissues upon exposure to living agents or inanimate substances. As originally framed, this definition was meant to include alterations in the direction of protection as well as in the direction of hypersensitivity, so that, strictly, immunology would also be connoted by the word. Von Pirquet felt that a single word was desirable to embrace all these different specific alterations in reactivity since he felt, as we do, that they were all fundamentally related biological phenomena".

In other words, the tissue that is allergic is so changed by a specific antigen (such as ragweed) that on subsequent exposures to this antigen, a reaction occurs. The modus operandi, of course, is: The antigen comes in contact with the tissue, antibodies to itself are produced during an incubation period, and a subsequent exposure to this antigen produces a reaction in the tissue because of the antigen-antibody union. This reaction is allergy whether it results in immunity or in harmful inflammation with clinical symptoms. When such an inflammation is in the nose, a rhinitis, commonly called hay fever, develops:

ALLERGY

(Antigen-Antibody Reaction)



and, when such an inflammation is in the pulmonary bronchi and bronchioles a condition of bronchitis plus bronchiolitis, generally known as asthma, ensues.

There are two distinguishing features between the inflammatory reactions caused by living organisms and those caused by inanimate substances. In both, toxic materials formed by the antigen antibody union produce the inflammation:

1. In the former (living antigen) the causative agent determines the character of the toxic material and the subsequent inflammation, as the tubercle bacillus producing a tubercle, the spirocheta pallida a chancre, or the staphylococcus an abscess.

2. In the latter (inanimate antigen) the tissue affected produces the toxic material and the type of lesion, as when the nasal mucosa reacts to pollen or animal danders. This antigen-antibody-cell union produces a rhinitis which is the same regardless of the agent causing it. In this type of lesion local eosinophilia during the first hour is the rule, unlike the bacterial inflammation in which neutrophiles or lymphocytes predominate from the very start.

This latter phenomenon (No. 2) has been clearly demonstrated experimentally by Kline, Cohen, and Rudolph[5] who injected various allergens into the skin of a number of allergic individuals, producing wheals that were histologically identical. These wheals were edematous inflammations with eosinophiliae as high as 80 per cent during the first hour, with gradual change to inflammatory processes indistinguishable from the ordinary bacterial inflammations.

In brief, clinical allergy (such as asthma, hayfever, or any other) represents an acquired altered capacity of a tissue to react with an antigen to which it was previously exposed. The resulting inflammation is the same for all antigens and is characterized by an eosinophilia.

Allergic reactions due to inanimate antigens may, however, be complicated by superimposed infection (animate antigen). Such infection frequently complicates the clinical picture.

Now, by keeping in mind the concept of allergy, all we need in order to have a nomenclature that is consistent with the rest of the medical literature, is to precede the organ affected by the descriptive adjective allergic, and to suffix it with "itis". For example, if the allergic inflammation be in the bronchial tubes, allergic bronchitis would indicate a definite entity, and if in the

nasal mucosa, allergic rhinitis would have a clear meaning. To complete a diagnosis, we may add the etiologic allergen, as allergic rhinitis due to pollen, or allergic rhinitis due to orris root. In this simple maner we have the means of constructing a nomenclature of allergic disease in the respiratory tract that is consistent with established medical language. The accompanying chart represents schematically such a classification.

The above terminology is self-explanatory. No new words have to be coined to describe allergic conditions: and these lesions should be uniformly interpreted by the average medical practitioner. All one has to keep in mind is the meaning of allergy.

THE TERM ASTHMA

The terms asthma and hay fever have been omitted because they are neither adequate, scientific, nor necessary. The word asthma has no uniform standard meaning. It is variously interpreted by different authorities. S. M. Feinberg[6] defines it as a "functional condition of the bronchi in which periodic or spasmodic attacks of dyspnea with prolonged expiratory phase are associated with wheezing, cough, and expectoration of tenacious sputum. The term 'bronchial asthma' so frequently used in medical writing, is a misnomer, since all asthma is bronchial."

M. B. Cohen[7] defines it as a "term applied to the symptoms resulting from the interference of the free flow of tidal air because of narrowing of the lumina of the bronchial tree".

F. M. Rackemann[8] calls it "a term which is loosely applied to a syndrome exhibited by patients who between attacks of asthma are subjectively and objectively well". Practically all medical writers include in the meaning of asthma any attack of dyspnea with wheezing whether the cause is cardiac, allergic, pulmonary or extrapulmonary. The American Illustrated Medical Dictionary (Dorland) states that "bronchial asthma" represents the allergic asthma; while Rackemann says "the adjective 'bronchial' appears to be quite unnecessary". In contrast to the term asthma, allergic bronchitis plus bronchiolitis can only mean one definite condition.

Similarly the name "hay fever" represents a misnomer. It has no relationship to hay as originally supposed. Nor is there any fever associated with this malady. Here again, the name allergic rhinitis due to pollen is strikingly definite in its description of the condition. It is systematic and self-explanatory.

SUMMARY

There is considerable confusion in the nomenclature of allergic conditions, including the very definition of allergy. The suffix "itis" and the descriptive adjective allergic are proposed to clarify the meaning of terms applied to allergic respiratory disease. This method "fits in" the general scheme of medical nomenclature.

BIBLIOGRAPHY

1. Tuft, L.: Clinical Allergy, W. W. Saunders, N. Y. 1938.
2. Vaughan, W. T.: Practice of Allergy. C. V. Mosby Co. St. Louis. 1939.
3. Urbach, E. and Gottlieb, P. M.: Allergy. Grune & Stratton, N. Y. 1943.
4. Boyd, C. W.: Fundamentals of Immunology, Interscience Publ., N. Y. 1943.
5. Kline. B. S., Cohen, M. B., and Rudolph, S. A.: Journal of Allergy, 6:531, 1932.
6. Feinberg, S. M.: Allergy in Practice, The Year Book Publ., Chicago. 1944.
7. Cohen, M. B.: A Manual of Allergy. Paul B. Hoeber, N. Y. 1941.
8. Rackemann, F. M.: Clinical Allergy. Macmillan, N. Y. 1931.
9. American Illustrated Medical Dictionary. Dorland, W. B. Saunders, Philadelphia, 1941.

Tuberculosis Among College Students

The Tuberculosis Committee of the American Student Health Association believes there is ample evidence to justify the following statements relative to case-find procedures commonly employed among college students:

1. The incidence of tuberculosis infection among college students is steadily decreasing. The majority of reports from colleges in 1943-44 indicate infection rates varying between 15 and 30 per cent.

2. The two-dose Mantoux method is recommended as the method of choice for tuberculin testing. If a single test dose is employed, an intermediate dose of at least 0.1 mg. O.T., or 0.0001 mg. P.P.D. should be used. The Vollmer patch test cannot be recommended for use in colleges.

3. The Mantoux test is highly dependable in eliciting sensitivity due to significant tuberculous infection or disease. It is sound practice, and in the interests of economy, to provide chest roentgenograms for only those students who react to an adequate dose of tuberculin.

4. Complete protection against tuberculosis for college students cannot be attained through a program limited to the student body. Faculty members and employees, including food handlers, should participate in the tuberculosis control program on the same basis as students.

5. The lesions of pulmonary tuberculosis encountered in college students are, in a majority of instances, unstable and potentially dangerous. The absence of symptoms does not preclude the necessity for early treatment. Students who remain in college having pulmonary lesions, should be under close observation with frequent clinical and roentgenographic studies.—H. D. Lees, M.D., The Journal-Lancet, Sept., 1945.

Cor Biloculare: Report of a Case

EDWARD W. MISKALL, M.D., and JOHN A. FRASER. M.D.

COR BILOCULARE, consisting of a single auricle and a single ventricle, is among the rarest of congenital cardiac defects. This case is presented because it had in addition to cor biloculare, transposition of the great vessels, a rudimentary atretic pulmonary artery, and dextrocardia.

REPORT OF CASE

D. E. R., a well-formed, white, male infant weighing 4.3 Kg. was delivered at full term, April 1, 1943, after a normal gestation. Respiration was spontaneous, but cyanosis was present from birth. Dyspnea became evident after 24 hours. No abnormal heart sounds were heard. A roentgenogram showed dextrocardia. The dyspnea and cyanosis rapidly became more intense, and death ensued after a survival of 3½ days.

The essential abnormalities at autopsy were in the heart. It weighed 27.0 gm. after fixation. (The normal weight of the unfixed heart at birth is from 20 to 25 gm.) The heart, globular in shape, lay almost entirely to the right of the mid-line. The great vessels had been severed at a level 1 cm. above the aortic valve. Two auricular appendages were present, but there was only one auricle. This single auricle was traversed antero-posteriorly by a thin muscular strand 2 to 3 mm. in diameter. This thin strand, the only semblance of an interauricular septum, expanded somewhat at its posterior extremity to disappear in the auricular wall (Fig. 1).

Four openings in the left side of the auricle were those of the pulmonary veins. The opening of the coronary sinus was not found. The right side of the auricle received the superior vena cava and the inferior vena cava. The pectinate muscles were well developed in the appendage on the right side of the auricle. The single auricle and the single ventricle communicated solely through one orifice which was guarded by a quadruple leaflet valve, the papillary muscles of which were poorly formed.

The wall of the common ventricle was from 3 to 5 mm. in thickness. The columnae carneae were well developed. A rudimentary interventricular septum extended from a point just below the left posterior aortic cusp, downward along the posterior wall of the ventricle toward the apex, where it widened noticeably (Fig. 2). This rudimentary septum averaged from 3 to 4 mm. in width and from 3 to 4 mm. in height. The single ventricle emptied through the aorta which lay slightly to the left of the midline of the heart. The aorta measured 7 mm. in diameter.

The aortic valve consisted of three normal appearing cusps, one anteriorly placed, and a left and right posteriorly placed. From behind each of the latter two cusps, arose a patent coronary artery. The left coronary artery supplied the posterior and left surfaces of the heart. The right coronary artery was distributed over the anterior and right surfaces of the heart. Directly posterior to the aorta was a small vestigeal pulmonary artery which measured 3 mm. in diameter (Fig. 2). It was proximally impermeable and expanded to a diameter of 5 mm. at the level of its severance. No valve cusps were visible. The complete transposition of the arterial trunks produced the mirror image of the normal relationship of the aorta, coronary arteries, and pulmonary artery to each other (Fig. 3).

Submitted January 14, 1946.

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COMMENT

Prior to 1942, only 37 cases of cor biloculare had been reported.[1] Several more have since been added. Abbott[2] in her analysis of 1,000 cases of congenital heart disease, listed nine in which cor biloculare was the primary lesion and an additional five cases in which it complicated other defects. Brown[3] divided the reported cases into complete and incomplete types. Persistent truncus arteriosus and complete absence of septal formation characterize the very rare complete form. Rudimentary septal formation and persistent ostium atrioventriculare commune are usually found in the incomplete type. The case presented typifies the latter.

The circulation in biloculate hearts is described by Wood and Williams[4] who maintain that there is a close resemblance between the circulation in the amphibian heart, as typified by the frog, and in the human biloculate heart.

Typically, in cor biloculare with atretic pulmonary artery, the ductus arteriosus is patent and communicates with the right and left pul-

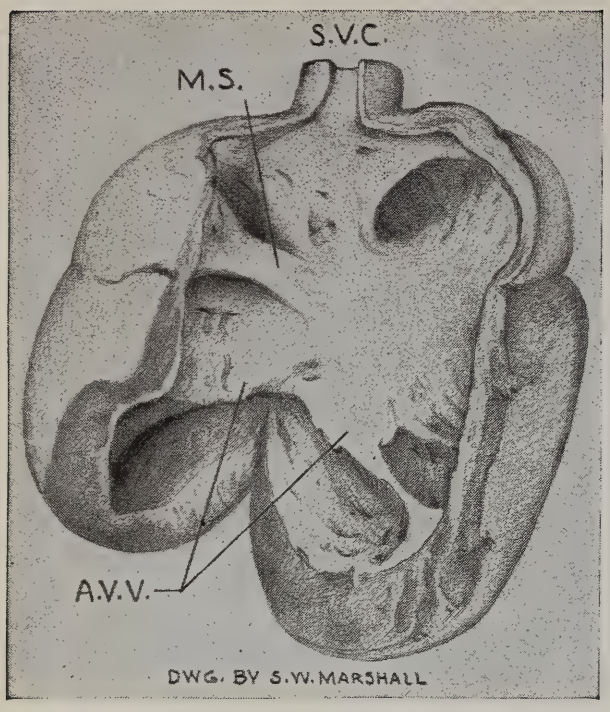


Fig. 1. Appearance of the heart opened longitudinally from behind. A.V.V., auriculoventricular valve; M.S., thin muscle strand stretching antero-posteriorly in the auricle; S.V.C., superior vena cava.

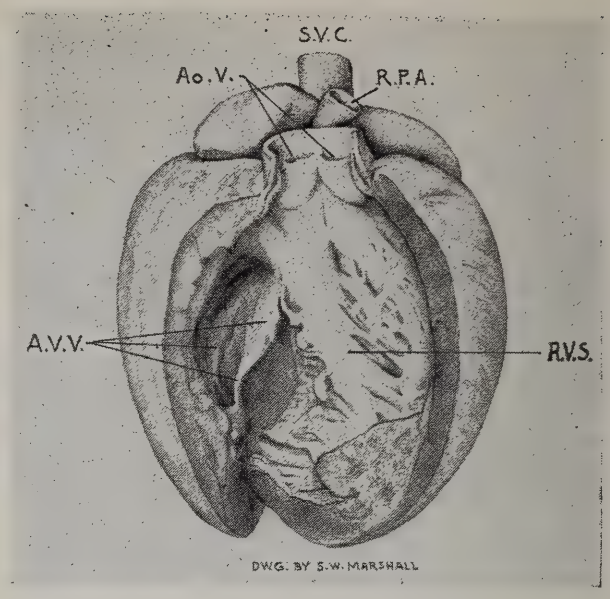


Fig. 2. Appearance of the heart opened longitudinally from in front. Ao.V., aortic valve; A.V.V., auriculoventricular valve; R.P.A., rudimentary pulmonary artery; R.V.S., rudimentary ventricular septum; S.V.C., superior vena cava.

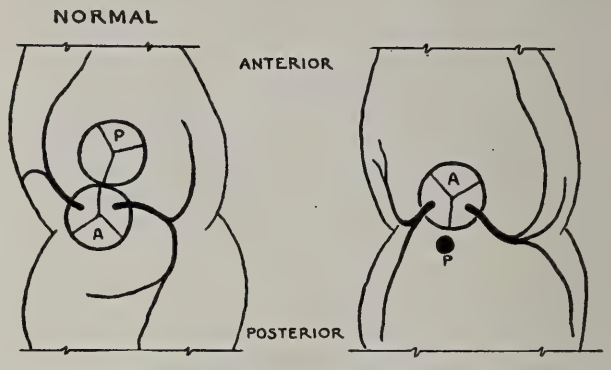


Fig. 3. Relationship of the arterial trunks and coronary arteries in the normal and in the transposition as represented by the case reported. The heart is shown as though sectioned coronally from apex to base. The anterior surface is shown above, and the posterior surface is below. The view is from above. A., aorta; P., pulmonary artery. Modified after Harris and Farber[6].

monary arteries. This is evidently a compensatory mechanism and provides that some of the blood from the aorta reaches the lungs. Unfortunately, in our case, the great vessels were cut off short, and the condition of the ductus arteriosus must remain doubtful.

Transposition of the arterial trunks is present in many of the reported cases. Rudolf's[5] case, with transposed arterial trunks, attained the greatest reported age, sixteen years. Transposition of the arterial trunks has been extensively studied by Harris and Farber.[6] Lev and Saphir[7] are of the opinion that transposition of the arterial trunks results from an abnormality in the absorption of the bulbus. This faulty absorption, in turn, is due to an abnormality of a particular bulbar ridge.

Their criteria for the diagnosis of transposition are (1) an abnormal position of the arterial trunks, (2) an abnormal position of the coronary ostia, (3) an abnormal topography of the right ventricular muscle bundles, and (4) an abnormal distribution of the coronary arteries. This case satisfies the first, second, and fourth criteria; but of the third, we can not be certain because of the rudimentary interventricular septum and because of the further complication of dextrocardia. The primitive stage of development of this particular heart precludes classification of the type of dextrocardia.

Life is usually short with this defect. In the nine cases listed by Abbott[2] in which cor biloculare was the primary lesion, the average duration of life was 3¼ years, the maximum 16 years, and the minimum 3¼ days.

BIBLIOGRAPHY

1. Rossman, J. I.: Cor Biloculare with Transposition of the Great Cardiac Vessels and Atresia of the Pulmonary Artery. Phylogenetic and Ontogenetic Interpretation. Am. Jr. Clin. Path. 12:534-542, Oct., 1942.

2. Abbott, M. E.: Atlas of Congenital Cardiac Disease, New York, American Heart Association, 1936, Chart I, pp. 60-61.

3. Brown, J. W.: Congenital Heart Disease, London, John Bale Medical Publications Ltd., 1939, p. 176.

4. Wood, R. H., and Williams, G. A.: Primitive Human Hearts. Am. Jr. M. Sc. 175:242-255, 1928.

5. Rudolf, R. D.: A Case of Cor Biloculare. Jr. Anat. and Physiol. 34:XVII-XX, 1899-1900.

6. Harris, J. S., and Farber, S.: Transposition of the Great Cardiac Vessels with Special Reference to the Phylogenetic Theory of Spitzer. Arch. Path. 28: pp. 427-502, Oct., 1939.

7. Lev, M., and Saphir, O.: A Theory of Transposition of the Arterial Trunks Based on the Phylogenetic and Ontogenetic Development of the Heart. Arch. Path. 39: pp. 172-183, March, 1945.

The Physician and the Cancer Patient

LOUIS M. PIATT, M.D.

THIS subject is not new and we add nothing to it. It is simply a plea to the general practitioner and family physician to stimulate greater effort toward earlier diagnosis and assume more responsibility in closer follow-up care of the cancer patient. A surprisingly large number of physicians are unaware of the aid and comfort they can give the cancer patient. A little more effort on their part can mean so much. Such effort is wholly lacking in glamor of scientific achievement and the results are lacking in spectacular features, yet they are very effective in results obtained.

There seems to be a general feeling of utter hopelessness among patients, patients' relatives and not infrequently among the attending physicians as to the eventual outcome of cancer in spite of the fact that it has been repeatedly demonstrated that a number of cancer patients can live for many years and some can be cured. We are of the opinion that more patients have lived longer than the records show. This opinion is based on a general observation that radiologists and surgeons in private practice often see earlier malignancies than are generally observed in large hospitals and clinics from whence come most reports. For various reasons the men in private practice fail to report their cases and their results.

No one speaks disparagingly of heart disease, tuberculosis, nephritis, diabetes, or many other diseases. These all require the continuous care of a physician over a period of years. Their eventual outcome is also as a rule predestined. They, too, require regulation of diet, frequent laboratory work, supportive medication, et cetera. Why, then, should the defeatist attitude be taken in the case of the cancer patient?

WHAT CAN THE GENERAL PRACTITIONER DO TO AID THE CANCER PATIENT?

Complete cooperation between the family physician and the oncologist, be he radiologist, surgeon, or both, as it is often the case, will in the end give best results. This after all is the prime purpose. The family physician should be constantly on the look-out for malignancy, for it is he who sees first the largest per cent of the malignant cases. The general rule that the earlier a malignancy is treated the better the chance of cure is well known. Therefore, there should be no hesitancy to biopsy doubtful cases and thereby establish an earlier diagnosis.

Submitted September, 1945.

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Our experience with referred cases is that of seeing benign or early ones from some physicians, to seeing those cases that are invariably late or hopeless, from others. However, it is not always the fault of the physician, for many times the patient fails to come in until his or her lesion has begun to give them a great deal of trouble or the cosmetic effect has become repulsive. Recently one such case of more than 10 years' duration was sent to our office. He had an epithelioma of the side of the face of at least 8 x 10 cms. in size. This epithelioma had destroyed all but the upper part of the ear. He had used various ointments and salves and the only reason for seeing the physician was that his barber refused to shave him any longer. It was not a question of finances. He had had relatively little pain.

The general public of today is well aware of the need for early diagnosis of cancer. This attitude should then be taken advantage of and the necessary biopsy specimen obtained.

When in doubt there should be no hesitancy in calling in consultation. A proper choice of consultants is, as a matter of fact, most important. Whether, the consultant be radiologist or surgeon, he should be above all cancer-minded, qualified, and have the necessary special training pertaining to malignancies.

EFFECTUAL TREATMENT

An important fact, and one that must not be minimized, is the knowledge that effectual radiation sufficient to produce results (a lethal tumor dose) must be given the patient harboring a malignant lesion. To give such radiation to produce an effect on the tumor makes it necessary that enough radiation be given to skin tolerance. Even then a lethal tumor dose is not always obtained.

Skin tolerance reaction manifests itself in erythema, dry desquamation, or moist desquamation (exudative dermatitis). This depends on the stage desired and is in a sense a "radiation

burn", but in reality it is a planned radiation dermatitis.

If the family physician knows this he will then refrain from telling the patient that he or she has an X-ray burn. The knowledge of having a so-called X-ray burn is of no comfort to the patient. In fact, it is detrimental, because most people have a horror of having an X-ray burn, for they can recall that some one told them of such a burn that never healed and an "open sore" resulted. The actual fact is that these radiation reactions heal within a few weeks.

The treating of persistent lesions with salves and ointments for weeks and months on end is to be condemned. It is the general opinion that lesions that fail to heal within a reasonable period of time after proper care need be investigated further. The false adage "that if a tumor doesn't bother you, why bother the tumor", is still too frequently used.

More attention should be paid to the physiologic aspects, such as diet, sleeplessness, pain and emaciation. There is no doubt that a cancer patient requires a most nourishing diet. Many of these patients lose their appetite and what little they do eat is generally insufficient to cope with the catabolic processes taking place. A well balanced high caloric diet with sufficient fruits and vegetables would certainly seem logical. As yet, there is insufficient evidence of the carcinogenesis of certain foods in the human. Hence that question need cause no worry. Tonics, stomachics, and vitamins of which a varied assortment can be had are indicated.

The problems of sleeplessness, restlessness, and worry are major ones. I know of no better way to lose weight, develop fatigue, exhaustion, and nervousness than to lie awake night after night thrashing about and worrying. Needless to say, these abnormalities should be alleviated. Very often it requires all the art and knowledge one possesses to combat these conditions. Proper environment and sedation skilfully applied are most beneficial.

Pain is a frequent symptom, especially in the latter stages of cancer, and it is difficult to control. The milder analgesics, such as the coal tar products, can be used at first. Cobra venom and demerol have given relief. Opiates are usually relied upon after the others have failed. These should be given in ample quantity to keep the patient in comfort. There is no point in allowing a cancer patient to suffer unnecessarily and the fear of addiction is certainly not to be considered in cancer patients. Radiation often affords relief in metastatic lesions. Sectioning of the sensory nerve roots has been done with success.

General supportive treatment such as cod liver oil, halibut oil, vitamins, vitamin B complex, liver extracts and iron compounds have proved of worth. All these should be given in large doses and continued over a long period of time. It is our impression that too little is given over too short a time.

The minimizing of complications, sepsis, uremia, and hemorrhage from which most cancer cases suffer in the last stages not only adds to the comfort of the patient but also makes it possible to "salvage" a certain number.

WHAT SHALL THE CANCER PATIENT BE TOLD?

There is no general answer to this question. Each case is an individual one and what is to be told the patient depends on the personal temperament of the individual. If the cancer has been recognized early and there is a good probability of a cure, the patient may be told, so that aftercare and repeated examinations may not be neglected. Prophecy in malignancy as to life expectancy is notoriously difficult. If, on the other hand, the cancer has progressed to the stage of incurability or hopelessness, then it would seem that it would not be best to tell the patient all the facts unless circumstances warrant otherwise. The necessity of arranging one's financial matters might indicate telling the patient the true conditions.

Under any circumstances, it is our opinion that some reliable and responsible relative should be informed as to the exact facts The family physician as a rule is in the best position to decide what to do since he knows the temperament of the patient best.

A thorough understanding between the physician and clergyman should be had before the latter begins his ministrations. Many patients do better if prepared. Others are just the opposite.

CONCLUSION

1. This is a plea for detailed care of the cancer patient.

2. Careful instructions in the comfort-giving procedures to those attending the cancer patient is most essential.

3. Periodic examinations to detect precancerous lesions and early cancer are the only means of insurance to many of the major forms of the disease.

4. There is a widespread fatalistic tendency to give up in despair when this disease is encountered. We do not deny that malingancy is difficult to handle, but this does not justify pessimism. On the other hand, it should stimulate greater effort towards earlier diagnosis and closer follow-up care.

5. When the cancer patient begins to receive this care and attention, the unorthodox practitioners will lose one source of their livelihood, namely, "the sure cure for cancer".

Sodium Pentothal Combined Anesthesia

H. HELFMAN, M.D.

SODIUM pentothal, because of its mode of administration, lacks the fingertip control which the anesthetist is accustomed to in inhalation anesthesia. In this regard it must be placed in the category of spinal anesthesia. This does not necessarily relegate it to the junk-pile but simply emphasizes its limited usefulness. It is now riding on a wave of great popularity because of its universal appeal. The patient is impressed by its comfort of induction and pleasant post-anesthetic recovery. At the same time, its ease of administration has appealed to the medical profession but has led to widespread abuse in the hands of the inexperienced.

The low number of fatalities reported in the literature is not a credit to many who have administered sodium pentothal. It simply indicates the wide margin of safety present in its use and is a tribute to the resistance and adaptability of the human organism. It is only when one respects its dangers and limitations that sodium pentothal takes its rightful place in the armamentarium of the anesthetist. Furthermore, when one learns to use it properly, he avails himself of many of its attributes which are ordinarily missed.

EFFECTIVE DOSES

In effective doses, sodium pentothal induces marked respiratory depression so that it was originally intended for brief and minor surgery. However, when properly combined with preanesthetic medication and mixtures of nitrous oxide-oxygen, the scope of its usefulness is widened and its safety enhanced. It is my custom to give morphine grains 1/6 and scopolamine grains 1/150 to the average adult one hour preoperatively. Barbiturates are purposely avoided because they add to the respiratory embarrassment. A 2 per cent solution of sodium pentothal is used (one gram in 50 cc. distilled water). This is injected slowly until the patient ceases counting and continued until the first plane of the third stage is reached. A 50-60 per cent of nitrous oxide-oxygen mixture is now begun by the semi-closed system. The CO_2 accumulation by this technic induces deep respiration and overcomes to a marked extent the depressant effects of the premedication and the sodium pentothal. Should the respirations become too labored, a soda lime absorber is introduced until the breathing quiets down and the process repeated.

SYRINGE HOLDER

I like the use of an intravenous syringe holder believing it to have considerable merit. It leaves one's hands free to control the nitrous oxide administration. Although realizing that there are as many varieties of syringe holders as there are anesthetists, I am partial to one designed by myself because of its simplicity (Fig. 1).

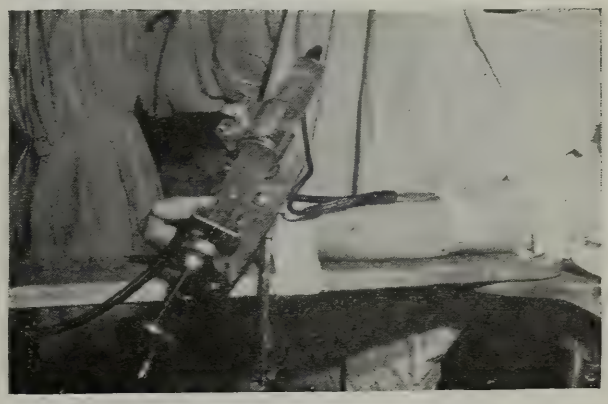


Fig. 1

A pharyngeal airway is a most desirable adjunct to this technic, but must be used with great caution in most cases. If the anesthesia is not deep enough to eliminate the pharyngeal reflexes, coughing, gagging, and laryngospasm may be introduced which is extremely annoying and eliminated with difficulty. But when successfully employed in prolonged procedures, combined with a headgear to hold the mask, a practically automatic system with minimal physical effort is obtained.

Although a 50-60 per cent nitrous oxide-oxygen mixture possesses but slight anesthetic properties, when combined with sodium pentothal, it exerts a definite synergistic action and markedly reduces the amount of sodium pentothal required. This is further influenced by the use of premedication. When properly combined, these three represent an admirable example of "balanced anesthesia" as advocated by Lundy[1] in which excessive doses of any one anesthetic agent is avoided. This method of

Submitted February 2, 1946.

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combined anesthesia is, to my mind, the most pleasant and one of the safest forms of anesthesia and has proved itself in many hundreds of cases without incident.

Sodium pentothal combined anesthesia has extended its use beyond the realm of short and simple minor surgery. I still believe that it has no place in major abdominal surgery (where relaxation is urgent) except as an adjuvant to spinal anesthesia. I have employed it satisfactorily in every form of surgery outside the major body cavities. Among them may be mentioned D. and C., trachelorrhaphy, anterior and posterior colporrhaphy, hemorrhoidectomy, fistulectomy, mastectomy, incision and drainage, skin grafting and orthopedic surgery. One must see it used in pinning a farctured hip of 2½-3 hours' duration to be impressed by its ease of maintenance and uneventful postoperative recovery.

CONCLUSIONS

In conclusion, I want to refer briefly to the use of sodium pentothal as an adjunct to spinal anesthesia. A major portion of the abdominal surgery (including the upper abdomen) at Middletown Hospital is done with hyperbaric pontocaine-glucose according to the Sise technic. Premedication to the average adult consists of nembutal grains 1½, two hours preoperatively and morphine grains 1/6 with scopolamine grains 1/150, one hour preoperatively. Immediately after spinal anesthesia has been induced, an intravenous drip of normal saline is begun. A 2 per cent solution of sodium pentothal is independently set up in a syringe holder and the needle injected into the rubber tubing of the intravenous drip (Fig. 1).

It must be realized that in this case the sodium pentothal is used for its soporific rather than for its anesthetic properties. Only sufficient sodium pentothal is injected at intervals to keep the patient asleep. If respiratory depression becomes too pronounced, I frequently augment this with a 50 per cent nitrous oxide-oxygen mixture by the semi-closed system. The advantages of this technic are manifold: It allays the fear of the apprehensive patient; it obviates the restlessness present in prolonged spinal anesthesia with the patient awake; it minimizes the nausea so frequently associated with spinal anesthesia; it permits the surgeon to discuss the case freely. I find that it is generally welcomed by both the patient and the surgeon.

BIBLIOGRAPHY

1. Lundy, John S.: Clinical Anesthesia, 1942.

2. Adams, R. Charles: Intravenous Anesthesia, 1944.

3. Schuhmacher, L. F., Jr., and Eversole, Urban H.: The Technics of Spinal Anesthesia; Anesthesiology, 3:630, Nov., 1942.

Prevention of Ringworm of Scalp

To conserve time, preventive measures will be listed only.

1. Detection of infected scalps by use of filtered ultraviolet rays before admission to school or institution.

2. Requirement of higher standards of barbershop technic, including sterilizing of electric and hand clippers, scissors, combs and brushes for each patron, especially for children under 16. (NOTE: Electric clippers with easily removable heads are preferred to other types. Dipping of clipper heads into boiling mineral oil for 2 minutes will sterilize without rusting.)

3. During emergency epidemic prevalence of ringworm, avoidance of use of unsterilized clippers for children under 16.

4. During epidemic prevalence, use of fungicidal ointment followed by shampoo of the hair promptly following having children's hair cut.

5. Avoidance of contact with kittens or puppies having infected patches of thin or bald fur. (NOTE: Filtered ultraviolet rays should be used to examine pets for ringworm.)

6. Avoidance of contact of children's heads with backs of seats in theaters.

7. Routine repeated examinations of all children contacts in the family with filtered ultraviolet rays.

8. Restriction of infected cases:

a. Avoidance of movies, barber shops, children's camps, and actual contact in playing with other children.

b. Exclusion from school until treatment is thoroughly initiated. Permission to be granted to return to school provided close fitting (stocking) caps sterilized by boiling 5 to 10 minutes daily be worn constantly and at home day and night until the disease is eradicated.

c. Patient to use only his own comb, brush, hat or cap, and to sleep alone.

The U.S.P.H.S. has just issued a press release evaluating the results of various drugs used for topical treatment. This is most timely and should be most helpful as a guide to therapy.—Joseph A. Murphy, School Medical Inspection Service, District of Columbia Health Dept.; Medical Annals of the District of Columbia, Vol. XV, No. 2, Feb., 1946.

The Diagnosis of Vegetal Foreign Bodies in the Lower Respiratory Tract

RAYMOND S. ROSEDALE, M.D.

THE incidence of overlooked or late suspected vegetal foreign bodies, particularly peanuts, in the bronchi, encountered by the author, has prompted him to write a short paper concerning the diagnosis of vegetal foreign body in the tracheo-bronchial passages with the hope that the information may be of interest to other practitioners.

The experience of the author in this direction is not unique, as Jackson and Jackson[1] state that among the cases of foreign bodies in children who were too young for subjective inquiry, more than 200 of them came with a history of "having had from 1 to 10 practitioners ignore, in some cases ridicule, the possibility of foreign body origin of their symptoms".

Perhaps the single most important feature in the history and diagnosis of a foreign body in the tracheo-bronchial tree is that of choking or gagging while eating nuts. With infants and children too young to give a history, the observation of others that the infant choked while eating or while playing with peanuts or other material is important. Sometimes the choking or gagging is spontaneous and other times it is associated with crying or talking while eating or following a slap or a push. The choking experience may be very severe, attended by redness of the face, cyanosis, and, in the case of young infants, accompanied by convulsions; or it may be so slight as to be just barely noticeable. Sometimes there is serious unproductive hacking cough for several hours or several days, and somethimes there is none.

Depending upon the location and size of the foreign body, there may or may not be audible wheezing. If present, this may be constant or intermittent. It may disappear to reappear with changes in position. Sometimes wheezing is the only symptom which brings the parents to the physician. As a rule these preliminary symptoms are not particularly pronounced. Foreign bodies which are large enough to be fixed in position are not attended by as much cough, or cough for as long a time immediately after the aspiration, as those which are small and move around in the tracheo-bronchial tree.

In from a few minutes to a few hours following the initial symptoms of gagging, coughing and choking, there is usually a symptom-free interval which may vary from one day to weeks, depending upon the nature, size and location of the foreign body. This latent period is unfortunate inasmuch as it is largely responsible for the ignoring of the possibility of foreign body aspirations by the laity as well as physicians.

With the development of vegetal bronchitis, cough will reappear. At first this is purposeless, hacking or irritating and unproductive. In cases of non-obstructive foreign bodies, expectoration is at first mucoid, then purulent, and, if ulceration develops, bloody in character as the inflammatory reaction develops. The amount of sputum depends on the degree of obstruction. In the later period of obstructive foreign body retention, there may be chills, fever, toxicity, and even hemoptosis. If the foreign body is partially obstructive, the symptomatology may be that of lung abscess, empyema or bronchopleural fistula. Peanuts are particularly irritating to the tracheo-bronchial mucosa and cause the formation of an unusual amount of fluid, which may be expectorated, or trapped distal to the obstruction. This exudate is at first serous and within several days, purulent. Pain is almost always absent with vegetal foreign bodies in the tracheo-bronchial tree. Unger[2] has stated that the possibility of the presence of a foreign body in the lower respiratory tract should always be entertained especially with a first attack of asthma.

Jackson and Jackson[1] list the principal reasons for overlooking the possibility of foreign bodies as:

1. Failure to consider the possibility of a foreign body.
2. Failure to elicit the history.
3. Absence of a history of foreign body.
4. Skepticism as to the possibility of a foreign body, in some instances even in the face

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of a very positive circumstantial history of the accident.

5. Apathetic attitude of the practitioner.
6. The symptomless interval.
7. Multiplicity of foreign bodies.
8. Waiting for expression of the foreign body.

The importance of establishing the diagnosis is especially striking in view of such figures as those of Jackson and Coates.[3] These authors state in regard to prognosis, that only 2 per cent to 3 per cent of patients recover if the foreign body is allowed to remain. In the latter regard, Jackson and Jackson[4] report that 2 per cent to 4 per cent of foreign bodies are coughed up, and that 99 per cent of tracheo-bronchial foreign bodies can be removed through the mouth.

PHYSICAL FINDINGS

Unfortunately, for the individual who has aspirated a vegetal foreign body into the lower respiratory tract, the early physical findings are usually not significant. This is one of the reasons that the attending physician may minimize or overlook the possibility of a foreign body. The general appearance of the patients is disarming. For the most part, they are calm, eat well, sleep well and present no signs of inflammation or suppuration.

According to Jackson and Jackson,[4] in those cases where a foreign body is in a large bronchus or is causing partial obstruction of the trachea, a wheezing may be heard at the open mouth. However, this wheezing may be absent or it may be almost inaudible or it may not be present all the time. The wheezing when present may be the only indication of pathology. Within 24 to 72 hours, the patient may develop a hacking, unproductive, irritating type of cough which usually is not great in degree nor frequent. At this time there may be diminution or suppression of breath sounds over the affected portion of lung. The breath sounds on the opposite side may be exaggerated. Rales are absent over the affected side. Tactile and vocal fremitus may be diminished. The percussion note may be slightly flattened if atelectasis is developing or slightly tympanitic, if there is emphysema. One must not make the mistake of interpreting the relatively increased harshness of the breath sounds and hyper-resonance on the unaffected side as being pathological. The trachea may be found to deviate from the midline. However, this is not an early sign.

Probably the most important single step in the examination of the patient is inspection of the chest and neck. This should be done in a good light with a side light available. One should observe whether there is unilateral impaired expansion and mobility of the chest. Frequently, also, one can determine whether or not there is widening of the intercostal spaces and change in movement of the supra or infra-clavicular fossae.

With the continued presence of the vegetal foreign body in the tracheo-bronchial tree, there is a localized or generalized exudative bronchitis. Especially in the case of peanuts this often is accompanied by an unusually large amount of exudate. If the exudate develops principally below the point of obstruction, rales may be heard over the obstructed part. If, also, it occurs above the point of obstruction, rales may be heard over other portions of the lungs because of the presence of this exudate or because of its irritating influence on the remainder of the normal bronchial mucosa. Such diffuseness of rales is unusual and when it occurs, may be confusing. A foreign body at the bifurcation of the trachea also may give rise to pathologic signs in both lungs.

Richards[5] has stated that the three commonest signs in the diagnosis of foreign body in the lower respiratory tract are unilateral limitation or expansion of the lung, hyper-resonance to percussion, and absent or diminished breath sounds.

X-RAY FINDINGS

The interpretation of the X-rays of foreign body of the tracheo-bronchial tree is sometimes difficult and should be done by those radiologists who are familiar with the pathology of foreign body aspiration.

In the earliest stages, the X-rays may show no departure from the normal. As secondary lung pathology develops, the changes in the X-ray pattern will depend upon the type, degree, and location of bronchial obstruction. If a main bronchus is totally obstructed, the air in the obstructed portion of lung parenchyma gradually will be absorbed. This leads to atelectasis of the involved part. If the right or left main bronchus has thus been obstructed, there will be a shadow of increased density over the entire lung on the obstructed side.

With the progression of the pathology, the trachea and mediastinum will be shifted to the involved side. Because of the limitation of respiratory excursion, the intercostal spaces will be narrowed. Also on the involved side, the diaphragm tends to be elevated. As time goes on, there may be a so-called compensatory emphysema of the opposite lung. This will be manifest as an increased radio-lucence and can be interpreted as hyperventilation. Sometimes this phenomenon is more obvious than the increased density in the atelectic lung and one must be on guard not to interpret the increased aeration as a manifestation of trapped emphysema.

If the foreign body has a so-called ball-valve or check-valve action, namely acting in such a manner as to allow the ingress of air but only a partial egress, the primary pathology will be

that of a trapping emphysema. Under these circumstances the affected parenchyma is gradually over-distended. In such a case, the trachea and the mediastinum will be seen to shift towards the unaffected side. The intercostal spaces will be widened, and the diaphragm on the affected side will tend to be depressed or flattened.

It is always well to secure films of the chest at the end of inspiration and at the end of expiration. Sometimes where there has been a trapping emphysema there may be a subsequent total or partial atelectasis. There are cases in which a rupture of the emphysematous lung causes a pneumothorax. This may cause some secondary collapse of the affected lung, in which case, a typical shadow of a pneumothorax with partially collapsed lung will be evident. Sometimes an interstitial pulmonary emphysema develops. The affected lung presents a mottled appearance due to contrasting pockets of air around the vascular and bronchial radicles. In such cases a mediastinal emphysema or a pneumothorax may develop and in two instances we have seen a consequent surgical emphysema of the chest and neck (Rosedale and Harkey).[6]

Foreign bodies do not always obstruct a main or first order bronchus. If a secondary bronchus is obstructed, a lobe will be affected. If a tertiary bronchus is obstructed, a portion of a lobe will be involved. The X-ray examination should be repeated on the third day following the removal of the foreign body and if no complications develop, on the seventh day. In the cases of involvement of a whole lung, an anteroposterior view may be sufficient. In cases where there is a questionable diagnosis, an oblique and lateral view should also be obtained.

When a foreign body has been in situ for some time, secondary parenchymal pathology may develop, such as multiple abscesses, or a "drowned" lung. If an abscess is peripheral, it may lead to hydrothorax or pyothorax. The secondary parenchymatous pleural pathology, may and frequently does obscure the primary lesion. In such cases the conventional X-ray examination may not be of value. One may supplement it by using a greater penetrative power of the X-ray to "delineate through", as it were, the overlaying obstructive pathology, or one may use laminography. If one suspects that a vegetal foreign body may be in the lower respiratory tract and there is not sufficient clinical and X-ray evidence to make a sure diagnosis, one should not hesitate to do an exploratory bronchoscopy to determine the presence or absence of a foreign body.

BIBLIOGRAPHY

1. Jackson, C., and Jackson, C. L.: Diseases of the Air and Food Passages of Foreign Body Origin. W. B. Saunders Co., Philadelphia, 1936.

2. Unger, L.: Bronchial Asthma. Chas. C. Thomas, Springfield, 1945, p. 320.

3. Jackson, C., and Coates, G. M.: The Nose, Throat and Ear and their Diseases. W. B. Saunders Co., Philadelphia, 1933, p. 1077.

4. Jackson, C., and Jackson, C. L.: Diseases of the Nose, Throat and Ear. W. B. Saunders Co., Philadelphia, 1945, p. 627.

5. Richards, L. C.: Vegetal Foreign Bodies in the Bronchi. Ann. Otol. Rhin. & Laryng., 50: 1941, p. 860.

6. Rosedale, R. S., and Harkey, J. M.: Foreign Bodies in Bronchus with Pneumothorax Occurring in Opposite Side of Chest. Ohio State Med. Jr., Jan., 1944, pp. 41-44.

The Deafened School Child

It is amazing that so little has been done in most communities in view of the fact that techniques for testing hearing and management of the deafened child have been perfected. It has been said that the cost was too great. This is fallacious. The cost of the entire program, i. e., screen testing for selection, the apparatus therefor, examination by qualified school otologists, lip reading—and even hearing aids for special children—is less than the cost of the years that deafened children repeat in school when the handicap is not detected.

Even in those communities where hearing tests are done, often the methods are inadequate according to modern concepts. Direct testing with voice or whisper has been repeatedly shown to be open to tremendous error (up to 200% of distance) unless a special monitoring instrument is used. It is now known that group testing with fading number phonograph records, such as described above, does not screen out all the children who are potential candidates for deafness and which could be picked up were more precise methods used. Pure-tone tests with an audiometer are more accurate and screen out many more children who are in need of help.

It is all very well to say that we are primarily interested in how well children hear speech and therefore it is only necessary to test for speech. This is not true. Speech tests are notoriously inaccurate and hard to evaluate, whether they are done directly or with a machine, and they give no information which can be used for diagnosis or prognosis. The pure tone audiogram on the other hand is accurate and can be interpolated so as to give an index of the patient's ability to understand speech.

For diagnosis, it is essential to test the hearing for both air and bone conduction. Audiograms could be done in groups with multiple bone conduction receivers, but in the present state of our knowledge, this is not advised for the physician can ascertain the essential bone conduction data in a few moments by doing bone conduction audiograms on all those children who have abnormal pure tone air conduction audiograms.—Edmund Price Fowler, Jr., M.D., New York; Nebr. State Med. Jr., Vol. 31, No. 3, March, 1946.

Primary Carcinoma of the Gallbladder: A Review of Cases at St. Alexis Hospital

FREDERICK G. HAMILTON, M. D.

AN observation that gallbladder carcinoma is not a frequent lesion and that it is so seldom diagnosed before biopsy has led to a review of the cases seen at St Alexis Hospital during the last 15 years. The cases studied either underwent surgery or were studied at autopsy, and were proved by microscopic examination.

Illingworth[1] states that he has had 36 cases out of 8,490 autopsies. Vital statistics reports[2] show that in one year 10,420 persons died of biliary tract malignancy and 143,613 of all forms of malignancy, of these 7 per cent died of biliary carcinoma. Lam[3] estimates that gallbladder carcinoma accounts for 4.5 per cent of all deaths due to malignant tumors. Boyce and McFetridge[4] collected 35,000 cases of gallbladder surgery and found that carcinoma constituted 1.1 per cent of these cases. Brown and Murphy[5] state that primary carcinoma of the gallbladder is three times as common as metastatic carcinoma. From these figures we can deduce that this disease contributes but a small percentage of total carcinoma cases, but is important enough to consider seriously.

SYMPTOMS AND DIAGNOSIS

The unfortunate fact of this disease with regard to its symptomatalogy is that its signs are not separate and distinct from other more common gallbladder diseases. The patients appear to fall into two classes. The first and larger class is that in which upper right quadrant pain, food dyscrasia, excess gas formation and constipation are seen. The other smaller group of patients show no previous pain or related history, with the possible exception of weight loss. As a rule these later cases show recent jaundice, which may be entirely silent, or may be accompanied by very recent pain, gas formation, postprandial vomiting, and clay-colored stool. The former group is usually diagnosed as chronic cholecystitis and cholelithiasis. The later group is most often thought to be a pancreatic carcinoma or a silent common duct stone. Nine of our patients belonged to the former group with long symptom histories while 4 showed only very recent signs and symptoms. Only 6 of the entire series showed any jaundice. Nausea and vomiting were at one time or another present in each case where the symptoms were of long duration. Weight loss and anorexia are usually present with any carcinoma. However, only 6 patients showed definite and severe loss of weight. Anorexia was noted in all patients.

A mass is sometimes felt upon physical examination; this was true in 10 of our 13 cases and was as a rule thought to be an enlarged liver.

Tenderness over the epigastric area or over the site of the gallbladder was noted in all of the cases. This was especially true of these patients having a palpable mass, the site of the mass being the area of tenderness. Other physical findings were usually lacking, with the exception of jaundice and cachexia in the cases previously mentioned.

An X-ray diagnosis of gallbladder carcinoma appears to be rather rare. This is probably because the roentgenologist only sees evidence of cholelithiasis and/or a non-functioning gallbladder. Carcinoma has no typical X-ray findings. Eight of our cases showed a non-functioning gallbladder; 4 others were X-rayed where reports were not obtainable. One examination showed a normal gallbladder function. Kirklin[6] of Mayo Clinic stated that he was able to diagnose papilloma of the gallbladder but had never made an X-ray diagnosis of gallbladder carcinoma per se.

SEX AND AGE INCIDENCE

With rare exceptions the patients with gallbladder carcinoma are in the carcinoma age. Jankelson[7] reports an unusually young patient, a male aged 22. The youngest patient in our series was 46 years of age and the oldest 70 years. The literature shows that the incidence is considerably higher in females than in males. Illingworth[1] sets a ratio of 4:1 and Lam[3] 2:1. Our own cases include 11 females and 2 males.

THE ROLE OF CHOLELITHIASIS

There has been considerable discussion as to the relationship of gall stones to gallbladder carcinoma and many men feel that they are an etiological agent. Stones were found in every case in this series with the exception of one which happened to be the youngest patient.

Submitted January 21, 1946.

The Author

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Judd and Gray[8] report a 46 per cent incidence, Lam 86 per cent. The incidence of cases of cholelithiasis which finally develop carcinoma has been estimated at 4-18 per cent. It is evident that cholelithiasis is not the only and direct cause for carcinoma development, for we see many patients with cholelithiasis of long standing who do not develop carcinoma of the gallbladder. Ashhoff and Bachmeister believe that stones are not a cause but are often formed in conjunction with and as a by product of the carcinoma itself. Stasis and poor function due to the carcinoma may be an etiological factor for stone formation in these cases.

Experimental attempts to produce gallbladder carcinoma have been carried on by Kozama[9] and by Leitch[10] and others. Foreign bodies, especially human gall stones, have been placed in the gallbladder of animals for great lengths of time. The experimental results were disappointing as the most change produced was a slight epithelial hyperplasia in guinea pig gallbladders. A review of experimental literature shows that the role of the stone as the etiological agent of carcinoma has not been proved. Thus, we feel that the clinician should at least regard cholelithiasis to be a warning signal as regards carcinoma of the gallbladder.

GROSS AND MICROSCOPIC APPEARANCE

Upon operation the condition was immediately suspected by gross examination in most cases. In one instance the gallbladder appeared normal and was removed with the diagnoses of chronic cholecystitis and cholelithiasis, a diagnosis of carcinoma being made by routine microscopic examination. The remaining cases showed a greatly enlarged gallbladder, thick and shaggy, and containing thick bile. It was firm and often had in association an involvement of the immediately surrounding liver bed. Four of our cases showed this adjacent involvement of the liver, one showed extension further into the liver by reason of extensive nodular formation. In the other 8 cases the carcinoma was confined strictly to the gallbladder itself.

Several authors have divided the microscopic findings into various types such as adenocarcinoma, scirrhous carcinoma, and squamous cell carcinoma. The majority of cases are of the adenocarcinoma type. In our series this was true of every case.

TREATMENT AND SURGICAL PROCEDURES

Treatment of established gallbladder carcinoma has given very poor results in the past. From a study of the subject it is felt that the prophylactic removal of chronically infected gallbladders and those containing stones would be an advisable practice. This if done early in the disease no doubt would save a certain amount of patients who later would develop carcinoma if not operated. Finsterer[11] has described a series of 114 cases of cholelithiasis which were followed for 10 to 25 years. These cases were all treated conservatively. Thirteen died of cholecystic disease, 25 underwent surgery for complications (of which 4 died) and 5 developed carcinoma of the gallbladder. From a retrospective view perhaps these 5 cases could have been saved by early cholecystectomy.

When the caricinoma is found established at surgery there is some question as to the procedure to be followed. It is the general feeling that a cholecystectomy should be done if easily possible. In cases where this procedure is not feasible due to extensive involvement of surrounding tissues some sort of palliative drainage is used such as cholecystostomy or some type of anastomasis. Gray[12] reports a radical procedure of cholecystectomy and partial hepatectomy by use of cautery. However, it appears that merely exploration and biopsy are the most frequent procedures. Four cholecystectomies, 4 cholecystostomies, and 4 biopsy and closures were done in our cases, the other case being purely an autopsy finding. From what we can determine no one procedure gave better results than the others.

Ten of our series are known to have died. The remaining 3 cases could not conclusively be checked. However, upon discharge, 2 of these 3 cases showed definite metastasis, and as both cases were studied over 5 years ago, we can assume that they have died in the meantime. These results compare favorably with the findings of other investigators. Lichtenstein and Tannenbaum[13] stated that in a series of 35 operated cases, 21 died in the hospital and of the other 17 only one is thought to be alive.

BIBLIOGRAPHY

1. Illingworth, C. W.: Carcinoma of Gallbladder Brit. Jr. Surg., 23: 4-18, July, 1935.
2. U. S. Bureau of Census: Vital Statistics, Special Reports, 5, No. 26, 63, April 5, 1938.
3. Lam, C. R.: The Present Status of Carcinoma of Gallbladder; Ann. of Surg:. Vol. III: 403-415, March, 1940.
4. Boyce, F. F., and McFetridge, E. M.: Carcinoma of Gallbladder; Critique Based on Analysis of Twenty-five Cases from Charity Hospital in New Orleans. Internat. S. Digest, 21: 67-79, Feb., 1936.
5. Brown, W., Brown, C., and Murphy, J. L.: Primary Carcinoma of the Gallbladder. South Western Med. Jr., Vol. 20: 172, May, 1936.
6. Kirklin, B. R.: Cholecystographic Diagnosis of Neoplasms of the Gallbladder. Proc. Staff Meet. of Mayo Clinic, 7: 384-387, Aug., 1932.
7. Jankelson, I. R.: Clinical Aspects of Primary Carcinoma of Gallbladder. New Med. Jr., 217: 85-88.
8. Judd, E. S., and Gray, H. K.: Carcinoma of Gallbladder and Bile Ducts. S.G.O., 55: 308-315, Nov., 1920.
9. Kozama, Y.: Studies on the Artificial Production of Tumors in the Viscera. Japan, Med. World, 2: 309-312, 1922.
10. Leitch, A.: Gall Stones and Carcinoma of Gallbladder an Experimental Study. Brit. Med. Jr., 2: 451-459, Sept., 1924.
11. Finsterer, H.: Das Karzinom den Gallenblase. Med. Klin, 28: 432-436, March, 1932.
12. Gray, H. K.: Squamous Cell Epithelioma of Gallbladder with Cholecystectomy and Partial Hepetectomy Report of a Case. Surg. Cl. N. Am., 14: 717-720, June, 1934.
13. Lichenstein, G. and Tannenbaum, W.: Carcinoma of thee Gallbladder. Ann. of Surg., Vol. III. 411-415, March, 1940.

Comments and Suggestions on the Psychiatric Aspects of the Vocational Rehabilitation Program

MILTON ROSENBAUM, M.D.

THE Vocational Rehabilitation Act as amended by Congress in 1943 has been considerably broadened to include patients with psychiatric disabilities as well as those with physical disabilities. The inclusion of psychiatric disabilities, which is certainly a progressve step, has made it necessary to define and to delineate clearly the various types of emotional and mental disorders which would fall within the provisions of this act. It is only natural that a good deal of confusion will exist at this time and perhaps for some time in the future around the problem of what constitutes a psychiatric disability and therefore this statement is being prepared to clarify certain points around which confusion can readily exist. It is recognized that this outline should be considered as only the first step in that direction and will have to be revised and changed as our experiences with these problems increase.

The goal of this program is to supply services necessary to render a disabled individual fit to engage in a remunerative occupation. Such services which lead to vocational rehabilitation include specific training and guidance in vocational fields, various types of necessary medical treatment, and, finally, opportunities for placement in employment.

LIMITATIONS REGARDING THE TYPE OF PSYCHIATRIC PATIENTS ACCEPTABLE FOR REHABILITATION:

1. Age of patient (16 or over).
2. Patient does not require permanent custodial care.
3. Patient must be more or less competent to handle his own affairs.
4. Patient is or can become physically competent to work and may be presumed to become self-supporting.
5. The client may be employed or unemployed. A disabled person whose disability prevents his being employed at his maximum capacity may be accepted for assistance in the removal of his disability or for job improvement training. Assistance with treatment may continue only temporarily after the client becomes employed and then only on basis of financial need.
6. The condition from which he is suffering should be "static". Static means that the condition is relatively permanent, arrested and relatively unprogressive. Perhaps the term static should be interpreted to mean that either the patient will not recover or be able to be employable without treatment, or treatment will shorten the recovery period considerably. By recovery is meant that treatment will either remove or substantially reduce the handicap and as a result the patient's employability will be substantially increased. With these limitations as a framework of reference, we can go on to the next point.

TYPES OF PSYCHIATRIC DISORDERS WHICH MAY BE ACCEPTABLE FOR TREATMENT:

(The fact that a patient has a psychiatric illness which would come under one of the categories listed below does not in itself mean that such a patient would be acceptable for treatment. This list is intended to serve as a guide to the type of psychiatric disorder which may be acceptable for treatment, but the final decision for acceptability rests in a total evaluation of the specific patient including such things as severity and chronicity of the disorder, prognosis, et cetera.)

1. Clients with static physical disability (amputations, blind, orthopedic disability, tuberculosis, et cetera) in whom emotional factors or mental attitudes are playing a role in the patient's disability and such factors and attitudes are hindering recovery or rehabilitation.
2. Clients who are disabled as a result of physical disease or injury (trauma) and in whom

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there is no longer any evidence of structural or organic changes which would result in a handicap or in whom medical or surgical treatment can offer little or no benefit and whose presenting clinical picture is that of a psychiatric disorder (neurosis) precipitated or influenced by the original illness. This would include that group of patients diagnosed as suffering from the traumatic neuroses and compensation neuroses.

3. Patients suffering from uncomplicated or pure psychiatric disorders which render them disabled.

(a) Any neurosis which has been chronic or disabling regarding employability (either the patient is unemployed or is crippled by his disability as to working efficiency).

(b) Patients with "static" psychosis who are not in institutions (although they may have previously been institutionalized) and whose social adjustment is such as to allow them to be employable under proper supervision and placement. This would include certain types of schizophrenia, paranoid states, depressions, et cetera.

(c) Disabling character disorders such as schizoid individuals, homosexuals and other types of sexual perversions.

(d) Psychosomatic disorders. This would include certain patients who are disabled by those illnesses (asthma, chonic gastric ulcer, certain types of cardiovascular disorders, migraine, et cetera) in which psychogenic and emotional factors may play an important role.

(e) Patients with organic brain disease and other types of neurologic disorders. This would include patients suffering from Parkinson's disease, residuals of infections, traumas, neoplasms, or cerebral vascular disease of the central nervous system, epilepsy, stationary tabes, et cetera.

PSYCHIATRIC CONDITIONS NOT ACCEPTABLE:

1. Mental deficiency of such a degree as to make the patients incompetent to handle their own affairs.
2. Patients in institutions.
3. Manic depressive psychoses.
4. Psychoses with cerebral arteriosclerosis and senility.
5. Psychoses with neurosyphilis (paresis).
6. Acute and chronic delirious reactions.
7. Certain types of psychopathic personality states.
8. Certain types of drug addicts (morphine, alcohol, et cetera).

WAYS IN WHICH CLIENTS CAN BE SPOTTED AND REFERRED FOR PSYCHIATRIC DIAGNOSTIC SURVEY AND TREATMENT:

1. All doctors participating in this program should be informed of the availability of psychiatric consultation and should be urged to request it when indicated. (Any doctor licensed to practice medicine and surgery in the State of Ohio is eligible to participate in this program, i. e., they are eligible to give the general physical examination required on all patients. Treatment, however, can be carried out only by those specialists qualified to give the particular type of treatment required.)

2. Requests for psychiatric consultation and treatment may come from social agencies, public or private clinics, or members of the Bureau who are familiar with the patient's history and presenting problems.

3. Requests coming from non-medical sources (social workers, psychologists, personnel departments, field workers, et cetera) or those cases in which there is some question as to the indications or advisability of psychiatric consultation, should be reviewed by a psychiatric social worker on the staff of the Bureau or by one of the psychiatric consultants chosen for this specific job before the client is referred for psychiatric consultation. The psychiatrist's pay for reviewing records should be based on the time spent in so doing at the same fee schedule already set up for office visits.

SOURCES TO BE UTILIZED FOR PSYCHIATRIC CONSULTATIONS AND TREATMENT:

1. Private psychiatrists whose qualifications meet the standards already set up. [The qualifications necessary to permit a physician to act as a psychiatric consultant for the Rehabilitation Bureau should be as follows:

(a) Diplomate of the American Board of Neurology and Psychiatry or

(b) Those practicing neuropsychiatrists with credentials acceptable to a sub-committee on credentials in psychiatry of the Medical Advisory Committee of the Rehabilitation Bureau.]

2. Accredited and approved public and private psychiatric clinics.

The main problem in this field has to do with those patients already being treated in public clinics and hospitals (municipal hospitals and clinics, et cetera) or who are eligible for such treatment (economic status) but who are at the same time eligible for treatment under the auspices of the Vocational Rehabilitation Bureau. This is a complex and far-reaching problem and is perhaps more pertinent to medical and surgical cases than psychiatric ones. It brings up the question as to whether the care of the medically indigent is primarily a responsibility of the local community, state, or Federal government. In those communities in which there are adequate public facilities for medical (including psychiatric) care, should the Vocational Rehabilitation Bureau assume further responsibility for medical service for their clients or should the

local community accept such patients as they would any other indigent patient?

Fortunately a recent statement from the Federal office has clarified this problem considerably. The statement is as follows:

> "The B. V. R. program has been set up to provide physical restoration services for clients where these services are not already available in the community. The Federal office will not share the costs of such services if the client is eligible for them by virtue of his residence in a community which provides these service for medically indigent residents. Should these services be available on a fee basis according to the ability of the client to pay, the client should be treated like any member of the community. Fees will be paid by B. V. R. for non-residents requiring community chest, health, and welfare agency services."

The Bureau will draw up contracts to cover financial arrangements with those public clinics and hospitals chosen to participate in the program. The choice of psychiatrist or clinic or hospital to be used should be mutually satisfactory to both client and Bureau within certain limitations. The medical service should be as close to the patient's home as possible to reduce traveling expenses. In those communities in which there is more than one psychiatrist, the patient should be given a choice if he so desires. In certain instances the patient may be referred to a certain psychiatric clinic or hospital which is better able to meet the needs of that specific patient. In these instances the decision should be agreed upon by a representative of the Bureau and the Psychiatric member (or his representative) of the Medical Advisory Committee.

FLEXIBILITY OF TREATMENT AND FEES:

The fees should be the same regardless of whether private or public clinics or hospitals are used. The length of treatment as defined by the law limits hospitalization to 90 days and ambulatory treatment to a "reasonable length of time". Obviously the latter phrase is not fixed and is open to interpretation. It is suggested that no client should be seen more than twice a week for a period of one month and not more than once a week for a period of two months unless the psychiatrist indicates that the patient is making definite progress and further treatment will be beneficial.

Routine X-rays of patients, nurses, and other hospital employees will not only disclose unsuspected tuberculosis which is extremely important to the individual but will also protect other patients and employees from the danger of infection. As more and more states are making tuberculosis a compensable disease, this factor will become increasingly important to hospital administration.—Karl H. Pfuetze, M.D., Med. Dir. and Sup't., Mineral Springs San., Cannon Falls, Minn.

Occupational Dermatitis

In fabricating steel products a variety of operations become necessary at which the operator's skin comes in contact with a variety of oils and other chemicals throughout the work day. Machining, grinding, washing, polishing, electroplating, inspecting, material handling, assembling, packing, and machine adjusting are mentioned as examples of jobs and operations required of skilled, semi-skilled and unskilled workers, male and female.

There is hardly ever a time during the process when the steel parts are not covered to some extent with petroleum oils and greases. Alkalies, chromic acid, and etching compounds are sometimes encountered. It is with the oils that we are particularly concerned in this study.

No attempt is made at this time to explain the chemical and physical nature of these oils but rather to review one year's experience with 368 cases of occupational dermatitis with special emphasis placed on etiology, incidence, diagnostic characteristics, and methods of personal cleanliness practiced by the employees.

Personal cleanliness is stressed since 88 per cent of the cases improved under treatment that included energetic washing.

METHOD OF PERSONAL CLEANLINESS

Although modern and adequate wash-up facilities are conveniently provided throughout the plant it was found that wash-up practices among dermatitis cases varied considerably in different locations. For example, in three locations it was revealed that the percentage who did not wash up or clean up in the plant was 2 per cent, 19 per cent, and 38 per cent respectively. This, in spite of the fact that advantages of good wash-up practices are constantly brought to their attention.

SUMMARY

1. An analysis is presented of one year's experience with selected data on 368 cases of occupational dermatitis.

2. 92.4 per cent of all cases were apparently caused by petroleum products, the highest rate being associated with mineral seal oil followed by cutting oil and the emulsions in that order.

3. Included are charts showing etiological agents, incidence by occupation, incidence by etiological agents plus location, and frequency of diagnostic characteristics.—Martin I. Hall, M.D., Bristol, Conn., Earl F. Lutz, M.D., and F. A. Patty, Detroit; Conn. State Med. Jr., Vol. X, No. 3, March, 1946.

An Unusual Case of Diffuse Carcinoma of the Stomach*

WILLIAM T. COLLINS, M. D.

CASE No. 200386. History: A 39 year old white female was admitted to the Cincinnati General Hospital on August 10, 1945, with the following complaints: Loss of weight from 186 to 145 pounds during the preceding 6 months, progressive abdominal distention for 3 weeks, mild constipation of 4 weeks duration, and low back pain. No history of abdominal pain, nausea, vomiting, jaundice, melena, or menstrual disturbances was elicited. The patient was married and had borne seven children, the last pregnancy being 7 years previously.

In 1931, the patient was in this hospital for 6 days and was discharged as improved with a diagnosis of low-grade salpingitis and laceration of the cervix.

Physical examination: Temperature 100°; pulse 100; respirations 24, and blood pressure 125/80. The patient was a chronically ill white female, having no severe pain. The heart was not enlarged, the rhythm was regular and no murmurs were heard. The chest was symmetrical at rest and during inspiration, and resonance and breath sounds were normal. The abdomen was markedly distended and there was slight epigastric tenderness but no muscular spasm or palpable masses were noted; the percussion note was dull and a fluid wave was readily obtained. There was tenderness in the right costovertebral angle. Pelvic examination disclosed a firm, irregular, immoveable cervix and bulging of the cul-de-sac with fluid; the fundus was not palpable and the adnexa were immobile. Rectal examination was not remarkable. No superficial lymphadenopathy was found.

Laboratory data: The initial blood examination on the day following admission showed a hemoglobin of 11 grams and 12,000 white blood cells. Two days later the white cell count was only 5,800 with 65 per cent polymorphonuclear leukocytes, 34 per cent lymphocytes, and 1 per cent monocytes, and subsequent counts revealed no significant variation from this determination. On the third hospital day, a hematocrit showed 47.9 volumes per cent of red blood cells and the plasma proteins were 6.02 grams per cent; on the 32nd day, these readings were 38.0 volumes per cent and 5.69 grams per cent respectively. The blood urea nitrogen was within normal limits and the blood Kahn was negative.

The urine, on three occasions, was essentially normal and no acid-fast bacilli were found in stained centrifuged sediment.

The ascitic fluid removed the day after admission showed the following: Specific gravity 1.018, 450 red blood cells per cubic millimeter, macrophages and diplococci, 3,875 mgm. per cent protein, 562 mgm. per cent chlorides, and no growth on culture. The sediment of the fluid was blocked and sectioned, but the slides presented insufficient evidence for microscopic diagnosis. The fluid removed by the second paracentesis was essentially the same as the fluid removed initially except for a slightly increased red blood cell content.

Stool cultures on the 26th, 27th, and 28th days were negative for the typhoid-dysentery group of organisms.

The tuberculin skin test was negative in a 1:10,000 dilution.

Course in the hospital: On the day following admission, 9,400 cc. of ascitic fluid were removed by paracentesis; the patient reacted well except for slight nausea and several liquid stools. The abdomen was soft with no palpable masses and peristalsis was present. Vaginal examination 2 days after paracentesis revealed a hard mass in the cul-de-sac which was diagnosed as carcinoma of the ovary and exploratory laporatomy was recommended. On the 4th hospital day, teleorontgenogram of the chest and antero-posterior and lateral films of the abdomen revealed no definite abnormalities. On the 6th day, exploration was performed through a right paramedian incision. The uterus, tubes, and ovaries were essentially normal but the entire colon was indurated, firm and immobile and the epiploic appendages were very hard. Two of the appendages were removed for biopsy and the incision closed without any further procedure, since the operator believed that the findings were possibly due to diffuse carcinoma of the colon or tuberculous enteritis. The microscopic diagnosis of the biopsy specimen was non-specific chronic inflammatory reaction.

Postoperatively, the wound healed rapidly, and the patient's condition was satisfactory except for mild persistent diarrhea and progressive recurrence of ascites. Intravenous mercupurin in conjunction with ammonium chloride by mouth was employed twice without any effect. On the 19th hospital day, a barium enema examination revealed marked irritability and narrowing with some evidence of ulceration in the sigmoid, transverse and ascending colons; these findings were interpreted as due probably to tuberculosis. On the 33rd day, a second teleoroentgenogram of the chest showed marked ascites of the abdomen and pleural thickening in the left costophrenic angle. The following day, paracentesis was again performed and 10,000 cc. of fluid was removed, following which a tender mass of "grape-fruit" size was palpated in the mid-abdomen. The patient was discharged on September 15, the 37th hospital day, with a diagnosis of tuberculous enteritis and peritonitis.

Readmission: On October 3, 1945, the patient reentered the hospital with the complaint of vomiting of fecal material for the past two days, associated with a decrease in the number of stools There had been no hematemesis, diarrhea, melena, or abdominal cramps or pain since discharge.

Abdominal examination revealed the presence of a large, firm, moderately mobile mass in the mid-abdomen, slight distention, a palable fluid wave, and hyperactive peristalsis. Pelvic exam-

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* From the Surgical and Pathological Services of the Cincinnati General Hospital, reported by the pathologist.

This is the twenty-sixth of a series of "Case Records Presenting Clinical Problems" selected by Richard S. Austin, M. D., Professor of Pathology, University of Cincinnati College of Medicine.

ination presented the same findings as noted on the initial admission. Flat and erect reontgenograms of the abdomen on the day of admission showed a general haziness over the entire abdomen and several slightly dilated loops of small intestine containing fluid levels. The carbon dioxide combining power at this time was 67.8 volumes per cent, and the blood urea nitrogen was 13 mgm. per cent. On the fourth hospital day, barium enema examination disclosed no intrinsic abnormalities in the rectum or colon, but there was a pressure defect in the transverse and sigmoid colon, thought to be due to adhesions.

A diagnosis of upper small intestinal obstruction was made, and after preoperative preparation with Wangensteen suction and intravenous fluids, an exploratory laporatomy was performed on the fourth day. Exploration revealed that the entire small intestine was represented by a large, firm, inflammatory mass. The colon, stomach, and pancreas were also involved by the inflammatory process. The pelvic peritoneum was studded with miliary nodules. It was impossible to relieve the obstruction and the incision was closed after removing a small portion of the pelvic peritoneum for biopsy. Microscopic examination of the specimen revealed a marked proliferation of fibrous connective tissue in which were scattered lymphocytes and peculiar bizarre cells with hyperchromatic nuclei; these were thought probably to be carcinomatous, but no definite diagnosis was reached.

The patient responded poorly postoperatively, remaining in peripheral vascular collapse until she expired on October 13, 10 days after admission.

The final clinical diagnosis was small intestinal obstruction due to chronic inflammatory disease of the abdomen or possibly to malignant neoplasm of the gastro-enteric tract.

Necropsy: Performed 15 hours after death. On opening the peritoneum, approximately 1,000 cc. of serosanguineous fluid was found in the peritoneal cavity. The visceral and parietal layers of the peritoneum were thickened and studded with numerous, slightly elevated yellowish-white nodules, measuring 1 to 2 mm. in diameter, and the loops of jejunum and ileum were firmly bound together by adhesions in a mass measuring 15 x 20 cm. The entire wall of the stomach was thickened, especially the posterior wall which measured 5 to 10 mm., and was composed of dense, fibrous, yellowish-white tissue; the lumen was moderately reduced and the gastric mucosa was slightly hyperemic but no ulceration was present. The pancreas, which was normal in size and consistency, was firmly adherent to the posterior wall of the stomach by fibrous yellowish-white tissue, and also adherent to the distal one-half of the transvere colon, the wall of which was markedly thickened. The mucosal surface of the small intestine, colon, and rectum presented no significant appearances other than a few small diverticula in the sigmoid colon. The ovaries were slightly enlarged and their surfaces were covered with tiny firm nodules.

Approximately 700 cc. of clear pale yellow fluid were present in the left pleural space. The lungs weighed 595 and 400 gms., right and left respectively, and showed lobular pneumonia in both lower lobes. The heart was small, weighing only 200 gms. The gallbladder had a slightly thickened wall and contained many, faceted, greenish-black stones. The other viscera presented no significant abnormalities.

On microscopic examination, the serosa of all the abdominal viscera was diffusely but sparsely infiltrated with small clumps and occasional acini of poorly differentiated neplastic cells which had pale staining, often vacuolated cytoplasms and irregular hyperchromatic nuclei; in many of the cells the nuclei were flattened and eccentrically located, forming typical signet-ring cells. The neoplastic infiltration of the serosa was accompanied by a dense connective tissue reaction producing marked serosal thickening. There was also a moderate lymphocytic infiltration and the serosal surfaces were covered focally with a thin fibrinous exudate. Sections of the ovaries showed invasion of the stroma by neoplastic cells.

The gastric mucosa was congested and slightly hypertrophied but presented no inflammatory reaction. In one area, the glandular pattern was distorted by growth of neoplastic cells which extended as thin strands through the muscularis mucosae into the submucosal and muscular layers. The submucosa and tunica muscularis of the stomach were diffusely infiltrated by neoplasm with a high proportion of stroma. Such appearances were not found in the remainder of the alimentary tract.

The other important microscopic findings were moderate generalized arteriosclerosis and lobular pneumonia of all lobes with extensive involvement of the lower lobes.

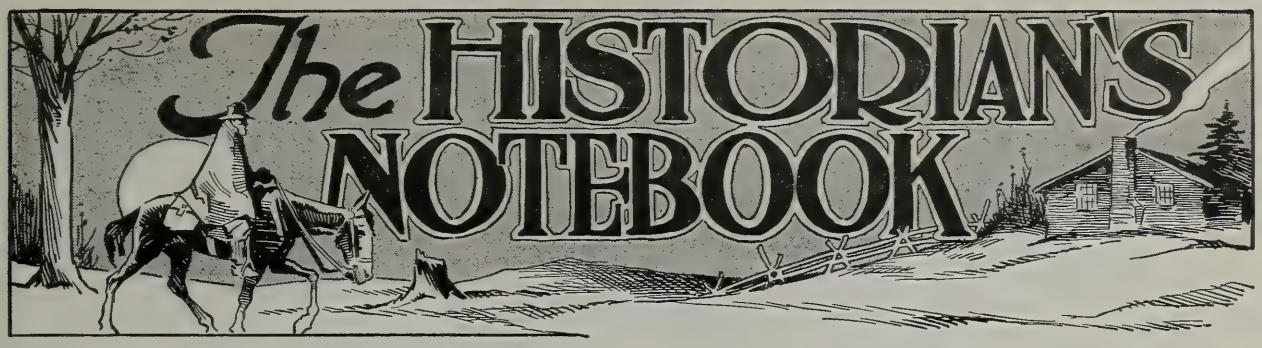
DISCUSSION

Clinically, the diagnosis of carcinoma of the ovary was entertained early in the course of observation of the patient. Following the first operation, abdominal tuberculosis was considered most likely and at the second and final operation, tuberculosis was still considered, but the biopsy report swayed the diagnosis to probable carcinoma of undetermined type and origin.

The gross findings at necropsy left some doubt as to the nature of the lesions. Carcinomatosis of the peritoneum or mesothelioma seemed most likely although non-neoplastic disease could not be excluded. The microscopic sections, however, left no doubt of the presence of primary carcinoma of the stomach, of the linitis plastica type, with metastases to the peritoneum and invasion of the ovaries.

This case is of particular interest in that the patient was only 39 years of age and that there was no early symptomatology referable to the stomach, but rather the complaints were those of peritoneal involvement. In contrast to the usual chronic course of linitis plastica, there was a relatively rapid progression of the disease in this case to a fatal termination.

During the past few years the combined use of the tuning fork and stethoscope has been found to be a valuable adjunct in physical diagnosis, particularly of the chest. Any ordinary tuning fork and stethoscope may be used. However, tuning fork No. 128C and the combination Bowles diaphragm stethoscope have been found to be most satisfactory.



Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio

The Vaulting Imagination of John L. Riddell*

ADOLPH E. WALLER, PH.D.

(Continued from the March issue)

THE VOYAGE FROM COLUMBUS TO CINCINNATI

It is interesting to record that his journey to Cincinnati was by water from Columbus, a method so completely fallen into disuse, that its existence as well as its present possibilities are forgotten. In Cincinnati, he knew no one, was even some time in getting letters to the men he wanted to meet. He was earning little money. The wrangles among the members of the medical profession in Cincinnati in the 1830's were almost interminable.

Daniel Drake[11] who had been a brilliant success in Phmiladelphia returned from Jefferson College and he thought to destroy the tottering Ohio College and build anew. Drake was accompanied on his return by John F. Eberle, whose Pennsylvania Dutch accent was as remarkable as his talent, by John Staughton and Thomas D. Mitchell and by John F. Henry whose home originally had been Kentucky. But he failed to arrange things as he wanted at the college and retired to private practice. These were the years in which Drake organized the Teachers College and at its annual meeting, in 1834, discussed the importance of the home in the child's environment. Modern educators would do well to examine some of the principles and problems that are so ably discussed by Daniel Drake.[12]

DANIEL DRAKE'S COLLEGE

When Riddell finally did succeed in calling on Drake he "inadvertently" dropped a letter of praise from Dr. Hildreth in a place sufficiently conspicuous for Drake to be certain to find it. One must be charitable toward this ruse as Drake's nod could find a place for Riddell and the neighboring entries indicate that he lacked money for food. Drake suggested that Riddell give some lectures and that he write an account of the plants of Franklin County. Drake had himself, at the Celebration of the Natives of Ohio, offered as a toast his "Tribute to the Buckeye Tree" which helped establish this tree as the official symbol of Ohio, "the buckeye of the West that possesses the power to permanently unite the hemlock of the North and the palmetto of the South in the same national arbor." Riddell would have gained much had he become more intimately acquainted with Drake. As it was, he became a member of the most brilliant medical faculty that had ever been assembled in the West. When the trustees of Cincinnati College announced the names of the faculty of the Medical Department the following names were on the roster: Joseph N. McDowell, anatomy; Samuel D. Gross, pathology; Horatio B. Jameson, soon succeeded by Willard Parker, surgery; Landon C. Rives, obstetrics; James B. Rogers, chemistry; John P. Harrison, materia medica; Daniel Drake, practice: John L. Riddell, adjunct in chemistry and lecturer on botany.[13] The Journal bears no record that Drake offered close companionship to Riddell.

It is noteworthy that Dr. Rogers with whom Riddell shared the chair in chemistry at the Cincinnati College became subsequently one of the great geologists of this country. All of the others remained actively engaged in medical teaching and practice, some of them continuing in Cincinnati.[11]

The name of most frequent occurrence in the

The Author

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part of Riddell's Journal relating to Cincinnati is that of John Locke,[15] who at the time of Riddell's arrival conducted a school for young ladies located on the east side of Walnut Street between Third and Fourth Streets. He also lectured at the Mechanic's Institute. Locke was a New Englander, born in 1792. While a medical student in 1816 he met Nathan Smith the founder of the Dartmouth Medical School, who encouraged him, offering a chance to lecture on botany at Dartmouth and other places. He conducted both indoor and field classes with such good effect that Dr. Jacob Bigelow of Boston, noted for the *Florula Bostonensis* and his great work on materia medica, heard of him and offered him a position as curator of the Cambridge Botanic Garden.

DR. LOCKE "A KINDRED GENIUS"

Locke, it seems, was too outspoken in his religious views and fell into disfavor in Boston. He embarked for the West Indies to study tropical plants as Navy Surgeon's mate, but the first hurricane he encountered frightened him into applying for his resignation. He returned to New Haven and obtained his medical degree, after which he came to teach at Transylvania. He must have known Rafinesque who at that date had not quarreled with President Holley sufficiently to resign. Locke rode horseback from Lexington to Cincinnati and fell in love with the place on sight from the hills, overlooking the Ohio River. He was later to design the Locke level, an improved galvanometer, and the magnetic clock or electro-chronograph. Although fifteen years older than Riddell the two quickly became friends and talked over Riddell's plan for a synopsis of western plants. As Riddell admiringly records in his personal Journal "we are kindred geniuses." It would be fair to state that Amos Eaton, Douglas Houghton, Samuel Hildreth, Daniel Drake and John Locke are the five intellects who most profoundly shaped the career of John Riddell, even though he was to part from Locke in bitter enmity.

Locke's school was not far from the Cincinnati College, and Riddell made many visits to Locke's home. They went on collecting trips together and Riddell met Mrs. Locke. The collecting and correspondence was more intense than any Riddell had previously attempted. He had completed his work on Franklin County shortly after his arrival in Cincinnati. The *Synopsis of Western Plants* was completed in 1835 and followed a year later by the supplement of the *Ohio Plants*. He meanwhile attended the lectures in Cincinnati College as well as demonstrating Roger's lectures in chemistry and lecturing in botany. Sometime between 1835 and March 16, 1836, the date of imprint of the *Supplementary Catalog of Ohio Plants* he had dropped the A. M. for an M.D. degree. He had also improved his method of recording his plant collections and cites localities and collector's names after many items in the list. He describes as new an *Aronia*, a *Habenaria*, a *Helianthus*, a *Linum*, two species of *Stachys*. He describes, without attempting to name, a different looking wild rose. He adds the pink moccasin, omitted from the *Synopsis*.

There is nothing in this attitude toward the work of naming the plants to which Sullivant can take exception and it hardly seems possible that Riddell's work could not have come to Sullivant's notice. Should one infer he chose to ignore it? The Worthington College, however, had probably been too democratic for Sullivant, and Riddell not sufficiently prominent in the group to measure up to Sullivant levels. Besides Sullivant did not really commence his major work in the Bryophytes until after Leo Lesquereux arrived in America. The catalog of plants in the vicinity of Columbus published by Sullivant in 1840 deserved more careful attention than to be tossed off with no reference to his predecessor's work.

HILDRETH'S INFLUENCE IN GEOLOGY

The field work Dr. Hildreth was eager to start in geology was also the basis of cementing friendly relations between Riddell and Locke in Cincinnati. In the message to the 35th General Assembly, Governor Robert Lucas had spoken warmly of the development of natural resources of Ohio. He did not mention Dr. Samuel Hildreth but it is more than likely that Robert Lucas was aware of Hildreth's plans for a geological survey. We have no evidence of it but Riddell probably spent the summer of 1835 in the field on both botanical and geological investigations and part of the time in the company of Locke and Increase A. Lapham. We do not know how he spent the summer after he had obtained his medical degree.

A student at Dr. Locke's school was Mary Schrager, also known sometimes as Mary Bone. She was an orphan from Baton Rouge and her Louisiana guardian, Mr. Holland, had put her in the provisional care of Nicholas Longworth. Mary had seen Riddell and thought him irresistible. She would walk up and down the street in front of the college in the hope of obtaining just a glimpse of him. At night, when all the young ladies were supposed to be safely in the school buildings, Mary would walk out to the corner and wait for John Riddell. She may have had a little more liberty than some of the other girls as her guardian in Ohio, Nicholas Longworth, was the uncle of Mrs. Locke. The flirtation between Mary and Riddell continued through the autumn of 1835 and into the spring of 1936.

As they became better acquainted Mary would walk as far as John's boarding house with him.

John could pass by the school grounds close to his boarding house. On one occasion he threw a note over the fence to a group of girls who were there and "thought" Mary picked it up. Mrs. Locke, however, intercepted it and passed it on to Nicholas Longworth, telling John Riddell she had done so. She thought that John's actions were open to serious question. The personal Journal seems to indicate they were, too. He writes that Mary came "in disguise" to his rooms. She seems to have visited him more than once and he writes that they will probably not remain continent if her visits continue. At the same time he is writing this in the Journal, he dispatches a note to Nicholas Longworth to indicate that Mrs. Locke has presumed too much in connection with the note he wrote Mary. Nothing had happened to excite an outburst from Mrs. Locke. Apparently his colleagues with the exception of John Locke, who was at the time not in the city, all knew about the note and the visits he had received from Mary. One advised Riddell to go to Kentucky and he married. Riddell waits petulantly for a few days for a reply from "the old goat" Nicholas Longworth.

HONEYMOON AND GEOLOGICAL TOUR

It is at this point that complete frankness in the personal Journal seems too much for Riddell. What he had recorded of his innocence, however, is followed by his marrying Mary in Kentucky. As he is all ready to start on a tour of duty for Hildreth's geological survey, he buys a horse and buggy and takes Mary across the State of Ohio with him.

We know how indebted Hildreth was to Riddell and that he used the report just as Riddell prepared it. But the report was not turned in to Dr. Hildreth first. Corroboratory evidence of this is officially available in the following letter:[16]

To the General assembly from Governor Joseph Vance. Gentlemen: Some days since I received a communication from John L. Riddell, M.D. enclosing a part of a geological report made in pursuance of a resolution of the last general assembly. I have subsequently received the remainder of his report which with a copy of his letter I herewith transmit for your consideration. —Joseph Vance.

When Riddell and Mary came back to Cincinnati at the end of summer, Dr. and Mrs. Wood and Dr. and Mrs. Rives refused to receive them. This was a severe blow as they had been apparently friendly all through the episode which had upset Mrs. Locke. But Riddell had, in the spring, received a letter from William Byrd Powell who had been teaching chemistry in the Medical College of Louisiana at New Orleans. He wrote to Powell and also to Mary's former guardian, Holland, and set out to locate Mary's property in Baton Rouge. Mary remained in Louisiana and apparently never returned to Ohio. She was shy and probably a little over-awed by the events in Cincinnati as well as by her husband's brilliant career. But she was a devoted wife to Riddell and bore him a son, Sanford. Through his management of Mary's property his financial troubles were over and he was established as a solvent citizen.

BIBLIOGRAPHY

1. "Catalogue of Plants Growing Spontaneously in Franklin County, Central Ohio; Excluding Grasses, Mosses, Lichens, Fungi, etc.," by John L. Riddell, M.A., Lecturer of Chemistry, *Western Medical Gazette*, II (July, 1834), 116-20, and *ibid.*, August, 1834, pp. 154-9.

2. Published by E. Deming, Cincinnati, 1835.

3. See A. D. Rodgers, *Noble Fellow* (New York, 1940), 105.

4. Mrs. Corinne Miller Simons of the Lloyd Library in Cincinnati; Miss Helen M. Mills of the Ohio State Archaeological and Historical Society Library, Columbus; Dr. Garland Taylor of tht Howard-Tilton Library; Miss Mary Louise Marshall of the Tulane Medical Library; and Mr. Walter Levy, U. S. N. R., a senior medical student at Tulane, have all helped guide me toward this material. All are warmly thanked. The last named is probably the only person who has read all that the Journal comprises. It is worth more serious study than the brief time at the writer's disposal permitted. Dr. Rickett of the New York Botanical Gardens has kindly furnished photostatic copies of Riddell letters to Dr. John Torrey.

5. Facts about Douglas Houghton can be seen in an article by Howard Kelly in *Cyclopaedia of American Medical Biography*, II, 14.

6. For a recent account of Dr. Hildreth see the *Ohio State Archaeological and Historical Quarterly*, LIII (1944), 313-38.

7. Not to be confused with Amos Eaton. U. U. Eaton was the editor of the Democratic *Free Press* in Detroit in which the announcements of Douglas Houghton's explorations and the Schoolcraft Expedition appeared.

8. See the Hildreth paper, *loc. cit.*

9. See Harvey W. Felter, *History of the Eclectic Medical Institute* (Cincinnati. 1902,) 12. Also Jonathan Forman, "The Worthington Medical College," *Ohio State Archaeolocial and Historical Quarterly*, L (1941), 373-9.

10. See footnote 1.

11. See Otto Juettner, *Daniel Drake and His Followers* (Cincinnati, 1909), esp. chap. V. Also E. R. Horine, *Daniel Drake and His Contributions to Education*, in *Papers of the Bibliographical Society of America*, XXXIV (1940), 303. Also Mary Louise Marshall. "The Versatile Genius of Daniel Drake," *Bulletin of the Medical Library Association*, XXXI (October, 1943), 291-318.

12. Daniel Drake, "Discourse on the Philosophy of Family, School and College Discipline," *Transactions 4th Annual Meeting of the Western Library Institute and College of Professional Teachers, Cincinnati, Oct., 1834* (Cincinnati, 1835).

13. See Juettner, *Drake*, for location of building, its size, appearance, etc., with illustrations of building and faculty members.

14. It is necessary for the present record to indicate that the Repository and Personal Journal of Riddell are not consecutively numbered and it is possible that certain ones are lacking in the collection in the Howard-Tilton Memorial Library. This is not surprising as they were presented more than three quarters of a century after Riddell's death. Just how confusing this is may be inferred from the following memorandum made while examining the volumes:

No. 5—contains notes from Marietta.
No. 6—was written in Cincinnati 1834-1836.
No. 7—Personal Journal commenced at Worthington, Dec. 20, 1832, and goes from Cincinnati to New Orleans, 1836-1837.
A second No. 7—contains minutes of lectures delivered in the winter of 1834-1835 at Cincinnati.
No. 8—is a personal journal made at Worthington, begun May 29, 1833.
No. 9—is a continuation of events of 1833.
No. 10—begins with the date, Dec. 20, 1833.
No. 11—begins with March, 1834 in Worthington.
No. 12—begins with July 17, 1834 in Cincinnati.

Attempting to read the above nine volumes is not unlike fitting picture puzzle pieces into their appropriate places.

15. See Juettner, *Drake*, 155.

16. Report No. 60 to the General Assembly. Dated Executive Office, Columbus, Mar. 9, 1937.

17. See John Uri Lloyd, and John Thomas Lyoyd, "A Librarian's Story." In *Journal of the American Pharmaceutical Association*, XX (Sept., 1931), 918-21.

(To be continued)

Proceedings of The Council

Program for Medical Care of Veterans Endorsed at Session Held on March 10; Action Taken on Federal Legislative Matters

A REGULAR meeting of The Council of the Ohio State Medical Association was held in the State Headquarters Office, Columbus, on Sunday, March 10, 1946. The following Officers and Councilors were in attendance: President Schriver, President-Elect McNamee, Past-President Sherburne, Treasurer Mitchell; Councilors Swartz, Messenger, Noble, Brindley, Dixon, Lincke, Swan, Micklethwaite, Harding, and Knoble. In addition to members of The Council, the following also were present: Dr. Harry V. Paryzek, Cleveland, Chairman of the Committee on Medical Care of Veterans; Dr. Roger E. Heering, Columbus, State Director of Health; Dr. S. H. Ashmun, Dayton; Dr. William M. Skipp, Youngstown, and Dr. H. M. Platter, Columbus, delegates to the American Medical Association; Mr Charles H. Coghlan, Columbus, Executive Vice-President of Ohio Medical Indemnity, Inc.; Executive Secretary Nelson, Assistant Executive Secretary Saville, and Mr. Page, News Editor of *The Journal.*

On **motion** by Dr. Sherburne, seconded by Dr. Swartz, and **carried**, the minutes of the last meeting of The Council held on December 16, 1945, were **approved.**

The Executive Secretary reported on membership statistics as follows: Total membership of the State Association as of March 8, 1946, was 5,832, of which 779 were military members; compared to a total membership of 6,904 on December 31, 1945.

MEDICAL CARE OF VETERANS

President Schriver then called on Dr. Paryzek to submit a report on the activities of the Committee on Medical Care of Veterans.

Dr. Paryzek reported that the Committee on Medical Care of Veterans had held meetings on February 3 and March 3, 1946. He stated that in response to bulletins transmitted to county medical societies, 40 county medical societies had reported the organization of local Committees on Medical Care of Veterans; and that 20 county medical societies had furnished, to date, lists of local physicians willing to make physical examinations for the Veterans Administration of disabled veterans applying for disability compensation.

Dr. Paryzek reported on conferences held with medical officials of the Veterans Administration, including General Paul R. Hawley at Washington, Colonel N. H. McNerney, Medical Director of Branch Office No. 9, Veterans Administration, Columbus, covering the States of Ohio, Michigan, and Kentucky; and Colonel B. A. Cockrell, Chief Medical Officer of the Cleveland Regional Office. He stated that all these officials are anxious to have the active help and cooperation of the Ohio State Medical Association and the physicians of Ohio, and that he felt any practical and reasonable program which would be recommended by the Ohio State Medical Association to provide medical care for veterans with service-connected disabilities would be approved and accepted by the Veterans Administration.

EXAMINATIONS BY SPECIALISTS

Dr. Paryzek reported that his committee had considered at its meeting on March 3 a request from the Veterans Administration that the State Association submit recommendations pertaining to the qualifications of consulting specialists for physical examinations authorized by the Veterans Administration. On behalf of the committee, Dr. Paryzek then presented the following recommendation of the Committee on Medical Care of Veterans, which, on **motion** by Dr. McNamee, seconded by Dr. Brindley, and **carried, was approved,** and the chairman of the committee was authorized to present the recommendation to the Veterans Administration with an additional recommendation that the Ohio State Medical Association would cooperate with and assist the Veterans Administration in determining which physicians meet the qualifications enumerated:

> "It is recommended that the following classes of physicians shall be considered by the Veterans Administration as qualified to serve as consulting specialists for examinations authorized by the Veterans Administration:
>
> "1. Physicians who are certified by their respective American Boards of Medical Specialties.
>
> "2. Physicians who may not be certified by their respective American Board of Medical Specialties but whose qualifications, when submitted by them to the Veterans Administration, are found by the Veterans Administration to be comparable to the qualifications required for admission to the examinations given by the appropriate American Board."

REPLY FROM OHIO MEDICAL

Dr. Paryzek then reported that his committee on March 3 discussed all angles with respect to the formation of recommendations for a statewide program in Ohio to provide disabled veterans with competent medical care, such care to be furnished by physicians in private practice

in the home communities of veterans whenever possible.

He stated that the committee had held conferences with officials of Ohio Medical Indemnity, Inc., on the possibility and feasibility of having Ohio Medical act as an intermediary agency on such matters under a plan similar to that which has been established in Michigan and California where the prepaid medical care plan of the medical profession has been designated as the intermediary agency. Dr. Paryzek stated that the officials of Ohio Medical had expressed themselves as favoring the principle of such a plan, but had stated that it would not be feasible for Ohio Medical to serve in such a capacity immediately inasmuch as the company has just started its activities.

In view of the above, Dr. Paryzek reported the committee felt that for the time being at least Ohio should handle this matter under a plan similar to that which is in operation in the State of Kansas with the approval of the Veterans Administration. Using the Kansas plan and other plans as patterns, Dr. Paryzek reported that his committee had drafted a proposed agreement between the Veterans Administration and the Ohio State Medical Association for the medical care of veterans with service-connected disabilities for the consideration of The Council and that the proposed agreement would be submitted to the Veterans Administration, if approved by The Council.

PROGRAM RECOMMENDED

The following proposal was then presented officially by Dr. Paryzek to The Council and was approved by The Council on motion by Dr. McNamee, seconded by Dr. Swartz, and carried, with instructions that the committee present the matter to the Veterans Administration at the earliest possible date:

"1. It is the purpose of the Ohio State Medical Association to collaborate with the Veterans Administration in a manner which will provide the best possible medical care for veterans residing in the State of Ohio.

"2. The Ohio State Medical Association will request all of its members to participate in a state-wide program whereby physicians in private practice will render medical services (examinations, treatments and counsel) in such cases as may be authorized by the Veterans Administration.

"3. The Ohio State Medical Association will submit to the Veterans Administration a list of members who desire to provide services for eligible veterans in home communities of such veterans.

"4. The physicians so listed will be appointed as fee-designated physicians of the Veterans Administration.

"5. Such list may be augmented from time to time as additional physicians indicate a desire to participate in the program.

"6. By notice in writing, a physician may at any time request that his name shall be removed from the list of fee-designated physicians.

"7. Fees for medical services in authorized cases shall be paid by the Veterans Administration to the physician rendering the service in accordance with the fee schedule which is attached hereto and made a part of this agreement. It is understood that unusually involved cases and services not scheduled will be subject to review and recommendation by the Ohio State Medical Association to the Veterans Administration for determination of appropriate fee.

"8. The Ohio State Medical Association will assist the Veterans Administration in establishing for examinations and treatments a list of competent specialists who meet the qualifications for specialists of the Veterans Administration.

"9. Lists submitted by the Ohio State Medical Association will be broken down by counties or districts in order that the veteran for whom services are authorized may select a physician practicing in his home community.

"10. The Veterans Administration will handle administrative and clerical details in connection with the authorization of examinations or treatments and the maintenance of records; and will arrange for transportation of the veteran if necessary.

"11. When authorizing examination or treatment, the Veterans Administration will furnish to the veteran proof of such authorization and a list of fee-designated physicians in the county or district in which the veteran is located in order that he may select his own physician for the services authorized.

"12. The Veterans Administration will review reports of examinations and services to determine their adequacy. No fees will be paid by the Veterans Administration for reports which are not acceptable to the Veterans Administration nor for services rendered in unauthorized cases.

"13. The Ohio State Medical Association will establish one or more boards of review composed of physicians. It shall be the duty of such board to review reports which are deemed by the Veterans Administration to be inadequate or which do not meet the requirements of the Veterans Administration; to recommend, at its discretion, the disqualification of any physician from further work with the Veterans Administration whose work is found by the board to be incomplete or unsatisfactory; to advise and assist the Veterans

Administration on other matters within the scope of this program.

"14. The Ohio State Medical Association does not propose to make any charge for any service rendered to the Veterans Administration under this agreement.

"15. This agreement shall become effective _____ and may be terminated by either party by giving thirty (30) days written notice to that effect.

"16. This agreement, if mutually satisfactory, may be renewed indefinitely for periods of one (1) year each, upon notice in writing to the contractor at least sixty (60) days prior to the expiration of each period of one (1) year, and written statement from the contractor within thirty (30) days after such notification agreeing to the renewal. Moreover, this agreement may be amended from time to time, if mutually satisfactory, through agreement in writing on the part of both parties."

FEE SCHEDULE BEING DRAFTED

Dr. Paryzek reported that a sub-committee of his committee is working on the proposed fee schedule referred to in Item 7 of the foregoing proposed agreement. He said that the committee had given the sub-committee power to act and the authority to prepare a schedule of fees which would be fair and reasonable, using the Ohio Workmen's Compensation Medical and Surgical Fee Schedule as a base. Dr. Paryzek said that the committee desired to have the endorsement of The Council with respect to this authority given to the sub-committee. Following a discussion, on **motion** by Dr. Brindley, seconded by Dr. Noble, and **carried**, The Council **approved** this action of the committee, giving the sub-committee authority and power to act on the matter of the fee schedule.

After Dr. Paryzek had completed his report, on **motion** by Dr. McNamee, seconded by Dr. Sherburne, and **carried**, The Council commended the Committee on Medical Care of Veterans for its fine work to date and expressed to the committee the fullest confidence and cooperation of The Council in its future activities.

FEDERAL LEGISLATION

Communications stating that hearings on the Wagner-Murray-Dingell Bill, S. 1606, would open in Washington on April 2 were read and discussed.

It was the sense of The Council that the Ohio State Medical Association should, if necessary, send official representatives of the Association to Washington to appear at the hearings on this bill and that such representatives should officially represent the Ohio State Medical Association. However, The Council felt that a delegation should be sent to Washington prior to the hearings to discuss this matter with Ohio's representatives in Congress and to obtain first-hand information on the Washington situation. On **motion** by Dr. Knoble, seconded by Dr. Swartz, and **carried**, the President was authorized to select a committee of three to go to Washington prior to April 2 for the purpose of obtaining information and presenting the views of this Association to members of Congress.

The question of establishing a national legislative committee was discussed. The members of The Council expressed the belief that the present Committee on Public Relations and Economics and the Sub-Committee on Legislation could efficiently handle such matters and, on **motion** by Dr. Sherburne, seconded by Dr. Dixon, and **carried**, these committees were specifically instructed to consider all matters on proposed national legislation, and that the American Medical Association be advised that this responsibility had been delegated to such committees.

A.M.A. PROGRAM ENDORSED

A report was submitted on interviews which had been held in many areas in Ohio with Ohio delegates to the recent national convention of the Y.W.C.A. with respect to the Wagner-Murray-Dingell Bill.

The recently announced national program of the American Medical Association, reported in the March issue of *The Ohio State Medical Journal* and in various issues of *The Journal of the A.M.A.*, was discussed. On **motion** by Dr. McNamee, seconded by Dr. Dixon, and **carried**, The Council unanimously endorsed the revised A.M.A. program and commended the American Medical Association for its progressive and forward-looking action.

REPORT ON PREPAYMENT PLAN

At this point Dr. Schriver called upon Mr. Coghlan for a progress report on the activities of Ohio Medical Indemnity, Inc. Mr. Coghlan reported that as of March 8 Ohio Medical had sold 5,000 contracts, involving approximately 12,500 persons in the 14-county area in Southwestern Ohio, and that approximately 60 groups were now in the process of being enrolled. Mr. Coghlan stated that in his opinion the company was making considerable progress and that there was widespread interest and enthusiasm in the area. He stated that just as soon as possible the company hoped to expand its activities into other parts of the state.

It was pointed out that Ohio Medical would apply for approval of the American Medical Association under the recently adopted "Standards of Acceptance for Medical Care Plans of the A.M.A.". One provision of the standards is that the medical care plan shall have a medical director acceptable to the county or state medical society or a committee appointed by either of

these groups to adjust difficulties and complaints. In order that there would be no question as to the compliance of Ohio Medical Indemnity, Inc., with this provision, The Council, on **motion** by Dr. Knoble, seconded by Dr. Dixon, and **carried**, designated the following committee to represent the Ohio Medical Association on matters of arbitration: Dr. Robert C. Rothenberg, Cincinnati, chairman of the Committee on Medical Service Plans; Dr. R. K. Finley, Dayton, a member of the Committee on Medical Service Plans; Dr. Barney J. Hein, Toledo, chairman of the Committee on Public Relations and Economics; Dr. C. C. Sherburne, Columbus, Past-President, Ohio State Medical Association; and Dr. Charles L. Ferguson, Portsmouth.

PEDIATRICS' SURVEY APPROVED

President Schriver then called upon Dr. S. H. Ashmun, Dayton, to address The Council. Dr. Ashmun stated that the Ohio Branch of the American Academy of Pediatrics is contemplating a state-wide survey of child health services as a part of a national survey under the auspices of the American Academy of Pediatrics. He stated that through such a survey, accurate and authentic information on the present personnel and facilities for the care and treatment of children would be tabulated and that accurate information would be secured as to the needs for additional personnel and facilities. Dr. Ashmun stated that he felt such a survey, under the direction of physicians, would receive proper guidance and that it would be far better to have such checkups made by the medical profession than by outside groups or governmental agencies.

The members of The Council felt that the proposed survey warranted the support of the Ohio State Medical Association and all its members and on **motion** by Dr. Messenger, seconded by Dr. Micklethwaite, and **carried**, The Council endorsed the proposed survey; authorized the President to publish a communication in *The Ohio State Medical Journal*, requesting all physicians to cooperate; and instructed the Executive Secretary to assist representatives of the Academy of Pediatrics in the distribution of communications and questionnaires.

IMMUNIZATION REPORT PLAN ENDORSED

Dr. Heering presented a proposal from the State Department of Health for distribution of an immunization report record to all parents at the time the Division of Vital Statistics sends inquiries verifying birth registration. Dr. Heering pointed out that the proposed immunization record sent to parents would accomplish two things: It would provide the Department of Health with information as to when children had been immunized or vaccinated and would tend to encourage parents to have such procedures done. Members of The Council offered a number of suggestions as to constructive changes in the proposed card and expressed themselves as believing this was a very meritorious public health procedure. On **motion** by Dr. Dixon, seconded by Dr. Mitchell, and **carried**, the plan for the card, as amended, **was officially approved and endorsed.**

ASK CHANGE IN E.M.I.C. FEES

Several communications from members, and a resolution adopted by the Dayton Obstetrical Society and endorsed by several County Medical Societies, objecting to the present policy of the State Department of Health in paying higher fees to diplomates of the American Board of Obstetrics and the American Board of Pediatrics for services under the E.M.I.C. program than the fees paid to physicians other than diplomates, were discussed.

On **motion** by Dr. Sherburne, seconded by Dr. Messenger, and **carried**, the resolution of the Dayton Obstetrical Society **was endorsed** and The Council authorized the sending of a communication to the State Department of Health, recommending that a uniform fee be paid to all physicians rendering services to beneficiaries of the E.M.I.C. program.

RAISE IN DUES DISCUSSED

Action of The Council at its last meeting, recommending an increase in the per capita annual dues of the State Association, was discussed. Reference was made to the publication of The Council's statement on this matter published in the March issue of *The Journal.* On **motion** by Dr. Sherburne, seconded by Dr. Harding, and **carried**, the Executive Secretary was instructed to prepare a resolution on this matter to be presented to the House of Delegates in May, and he was authorized to send reprints of The Council's statement, published in the March issue of *The Journal*, to the presidents and secretaries of county medical societies and to each delegate and alternate to the State Association.

The Executive Secretary reported that plans had been virtually completed for the Centennial Anniversary meeting of the Association, May 7, 8, and 9, Columbus. On **motion** by Dr. Messenger, seconded by Dr. Lincke, and **carried**, The Council approved the scheduling of meetings of the House of Delegates for Tuesday, May 7, 10:00 A. M. and Wednesday, May 8, 9:00 A. M.

On **motion** by Dr. McNamee, seconded by Dr. Brindley, and **carried**, The Council authorized the Executive Secretary to invite all Past-Presidents to be the guests of the Association at the Centennial Anniversary Banquet on the evening of Wednesday, May 8.

RESIGNATION; VACANCY FILLED

The Executive Secretary then read to The Council a letter from Dr. George T. Harding,

Columbus, submitting his resignation as a member of The Council representing the Tenth District. The text of the letter was as follows:

"I hereby submit my resignation as a member of the Council of The Ohio State Medical Association, representing the Tenth District, to you, as President of the Association.

"While elected as Councilor for the Tenth District at the last annual meeting of The Ohio State Medical Association, I was originally appointed to fill the vacancy created by the resignation of my friend, Doctor Harve M. Clodfelter, when he was commissioned in the Navy in 1942.

"I have enjoyed my time as Councilor as much or more than any other experience I have had of this kind and have looked forward to the all-day sessions on Sundays with the greatest of pleasure. I have been rewarded with a growing appreciaton of the work and responsibilities of the Association and even more, with an understanding of how much the medical profession as a whole owes to its elected and appointed representatives in the offices of the Association, its Council and committees. I realize as never before the importance of the local societies and of the function they fill by integrating the work of the doctor in practice and the complex social structure and its ever changing form in the world of today and tomorrow.

"I am proud to have been a member of the Council during the past few years when issues of tremendous importance were being met and dealt with. I have formed a feeling of profound respect as well as affection for each and every member of our organization. I offer my resignation with sincere regret for I will miss the stimulating discussions under your leadership and the friendly contacts with my fellow Councilors. However, in accepting the appointment in 1942, I did so with the thought in mind that I would turn the honor back to Harve Clodfelter as soon as he became a civilian again.

"I am sure that The Ohio State Medical Association will be benefited by having, as a member of its Council, one of its own members who resigned to enter the armed services, has served with distinction and has now returned to represent not only the Tenth District but also the large group of service men who have brought new honors to our profession by their services to our country in this last war.

"Inasmuch as Doctor Clodfelter is now established in his office and is ready to resume a place on Council I would like to request that my resignation be effective at once. My interest in the work of the Association will continue and if I can be of any further service on committees at any time I will be honored to have you call on me."

On **motion** by Dr. Swartz, seconded by Dr. Noble, and **carried**, The Council accepted with sincere regrets and appreciation the resignation of Dr. Harding.

On **motion** by Dr. Sherburne, seconded by Dr. Swartz, and **carried**, The Council elected Dr. Harve M. Clodfelter as a member of The Council to serve the unexpired term of Dr. Harding, which term ends at the time of the Annual Meeting in 1947.

MISCELLANEOUS BUSINESS

A communication from Mr. P. C. Rowland, President of the Ohio Association of Accident and Health Underwriters, suggesting conferences on matters of mutual interest, was read and discussed. On **motion** by Dr. McNamee, seconded by Dr. Messenger, and **carried**, the Executive Secretary was instructed to confer with Mr. Rowland and other officials of that Association on this matter.

A letter from Mr. Jack Kroll, President of the Ohio C.I.O. Council, was considered. On **motion** by Dr. Sherburne, seconded by Dr. McNamee, and **carried**, the communication was referred to the Committee on Public Relations and Economics for study, inasmuch as the letter involved questions of legislation, and the committee was authorized to obtain legal counsel, if necessary, while considering the question.

The Executive Secretary reported to The Council on the activities of the Joint Committee on Tuberculosis Control in Ohio, of which he is a member. Members of The Council were requested to encourage all county medical societies to appoint official representatives on county committees which are being organized under the direction of the state committee.

Dr. Platter submitted a report on the 19th Annual Meeting of the National Conference on Medical Service, held in Chicago on February 10, 1946, which he attended at the request of the State Association.

Dr. Schriver submitted correspondence involving a returned medical officer who has been unable to resume his former employment with a serological laboratory because of qualifications laid down by the State Department of Health on the approval of laboratories. On **motion** by Dr. Sherburne, seconded by Dr. Dixon, and **carried**, The Council referred the correspondence to the Executive Secretary for an investigation and report to The Council at its next meeting.

On **motion** by Dr. McNamee, seconded by Dr. Mitchell, and **carried**, the Executive Secretary was authorized to develop plans for the operation of an Ohio State Medical Association Special Train for members of the Association and their wives who expect to attend the meeting of the American Medical Association in San Francisco, July 1-5.

There being no further business, The Council adjourned to meet on the evening of Monday, May 6, for dinner at the Neil House on the eve of the 1946 Annual Meeting.

Attest: CHARLES S. NELSON,
Executive Secretary.

Centennial Anniversary Meeting

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OHIO STATE MEDICAL ASSOCIATION

Commemorating a Century of Progress in Medicine

Tuesday, Wednesday, and Thursday
MAY 7, 8, and 9, 1946

Neil House and Deshler-Wallick Hotel
COLUMBUS, OHIO

COMPLETE PROGRAM DETAILS ON FOLLOWING PAGES

Summary of Program

TUESDAY, MAY 7

9:00 A.M. *Opening of Registration Headquarters.*
Junior Ballroom, Mezzanine Floor, Neil House.

Formal Opening of Technical Exhibits.
Mezzanine Lounge and Junior Ballroom, Neil House.

10:00 A.M. *First Session, House of Delegates.*
Main Ballroom, Mezzanine Floor, Neil House.

2:00 P.M. *First General Session.*
Main Ballroom, Mezzanine Floor, Neil House.
Homer F. Swift, M.D., New York, N.Y.; W. J. Zeiter, M.D., Cleveland; Thomas P. Sharkey, M.D., Dayton; Allan C. Barnes, M.D., Columbus; W. James Gardner, M.D., Cleveland; and A. B. Brower, M.D., Dayton.

8:15 P.M. *Second General Session.*
Main Ballroom, Mezzanine Floor, Neil House.
Frank F. Tallman, M.D., Columbus; and Stanley P. Reimann, M.D., Philadelphia, Pa.

WEDNESDAY, MAY 8

9:00 A.M. *Second and Final Session, House of Delegates.*
Victory Room, Lobby Floor, Neil House.

Sessions of Scientific Sections:

Section on Eye, Ear, Nose and Throat,
Room 1540, Deshler-Wallick Hotel.

Section on Medicine,
Main Ballroom, Mezzanine Floor, Neil House.

Section on Obstetrics and Gynecology,
Red Room, Mezzanine Floor, Neil House.

Special Society Meetings:

Ohio Society of Anesthetists,
Room 1440, Deshler-Wallick Hotel.

Ohio State Radiological Society,
Room 1337, Deshler-Wallick Hotel.

Ohio Society of Pathologists,
Hamilton Hall, Ohio State University.

12:15 P.M. *Luncheons:*

Section on Nervous and Mental Diseases,

Garden Room, Mezzanine Floor, Neil House.

Ohio Chapter, American College of Chest Physicians,

Coral Room, Mezzanine Floor, Neil House.

12:30 P.M. *Ohio State Radiological Society,*

Parlors H and I, Deshler-Wallick Hotel.

2:00 P.M. *Third General Session.*

Main Ballroom, Mezzanine Floor, Neil House.

Walter L. Palmer, M.D., Chicago, Ill.; Roy D. McClure, M.D., Detroit, Mich.; Carl V. Moore, M.D., St. Louis, Mo.; William H. Feldman, D.V.M., D.Sc., Rochester, Minn.; Charles F. McKhann, M.D., Cleveland; and Brigadier General William C. Menninger, Washington, D.C.

7:00 P.M. *Centennial Anniversary Banquet.*

Main Ballroom, Mezzanine Floor, Neil House.

Presentation of Past-President's Gavel and Introduction of Incoming President, President-Elect, Officers, Councilors, and Past-Presidents.

Address: Philip D. Jordan, Ph.D., Minneapolis, Minn.

THURSDAY, MAY 9

9:00 A.M. *Sessions of Scientific Sections:*

Section on Nervous and Mental Diseases,

Room 1337, Deshler-Wallick Hotel.

Section on Pediatrics,

Victory Room, Lobby Floor, Neil House.

Section on Public Health and Preventive Medicine,

Room 1540, Deshler-Wallick Hotel.

Section on Surgery,

Main Ballroom, Mezzanine Floor, Neil House.

Registration Information

In compliance with Chapter 1 of the By-Laws of the Ohio State Medical Association, physicians who are members in good standing of the Ohio State Medical Association and physicians who reside in other states and are members in good standing of their respective state medical associations will be permitted to register and attend the various Annual Meeting sessions. Medical students, interns, residents, nurses, health workers, and others attending the meeting as guests of members of the Ohio State Medical Association and presented by them to the Registration Headquarters, may register as guests and will be admitted to all sessions.

Admission to all sessions will be by badge only, which badge may be secured upon registering. Registration Headquarters will be open daily from 9:00 A.M. to 5:30 P.M., and will be located in the Junior Ballroom on the Mezzanine Floor, Neil House. No registration fee.

TUESDAY MORNING, MAY 7

10:00 O'Clock

FIRST SESSION—HOUSE OF DELEGATES

Meeting Place—Main Ballroom, Mezzanine Floor, Neil House

TUESDAY AFTERNOON, MAY 7

2:00 O'Clock

FIRST GENERAL SESSION

Meeting Place—Main Ballroom, Mezzanine Floor, Neil House

CHARLES A. DOAN, M.D., Columbus, *Chairman,* Committee on Scientific Work, presiding.

2:00 to 2:30 O'Clock

Relationship Between Rheumatic Fever and Hemolytic Streptococcal Infections

HOMER F. SWIFT, M.D., New York, N.Y.,
Member, Rockefeller Institute for Medical Research.

2:30 to 3:00 O'Clock

The Place of Physical Medicine in General Practice

W. J. ZEITER, M.D., Cleveland.

3:00 to 3:30 O'Clock

Management of Malaria

THOMAS P. SHARKEY, M.D., Dayton.

3:30 to 3:45 O'Clock

Recess to Visit Exhibits.

3:45 to 4:15 O'Clock

The Status of Sex Hormone Therapy in Present-Day Practice

ALLAN C. BARNES, M.D., Columbus.

4:15 to 4:45 O'Clock

Diagnosis of Non-Traumatic Intracranial Lesions

W. JAMES GARDNER, M.D., Cleveland.

4:45 to 5:15 O'Clock

Coronary Heart Disease

A. B. BROWER, M.D., Dayton.

Adjournment for Inspection of Exhibits.

TUESDAY EVENING, MAY 7

8:15 O'Clock

SECOND GENERAL SESSION

Meeting Place—Main Ballroom, Mezzanine Floor, Neil House

CHARLES A. DOAN, M.D., Columbus, *Chairman,* Committee on Scientific Work, presiding.

8:15 to 9:00 O'Clock

Mental Hygiene Program for Ohio

FRANK F. TALLMAN, M.D., Columbus,
Commissioner of Mental Hygiene, Ohio Department of Public Welfare.

9:00 to 9:45 O'Clock

Present Status of Cancer Research

STANLEY P. REIMANN, M.D., Philadelphia, Pa.,
Director, Research Institute, Lankenau Hospital, and Institute for Cancer Research; Associate Professor of Surgical Pathology, University of Pennsylvania School of Medicine.

WEDNESDAY MORNING, MAY 8

9:00 O'Clock

SECOND SESSION, HOUSE OF DELEGATES

Meeting Place—Victory Room, Lobby Floor, Neil House

WEDNESDAY MORNING, MAY 8

9:00 O'Clock

SECTION ON MEDICINE

Meeting Place—Main Ballroom, Mezzanine Floor, Neil House

ROBERT C. ROTHENBERG, M.D., Cincinnati.....*Chairman*
FRANK M. WISELEY, M.D., Findlay.....*Secretary*

9:00 to 9:30 O'Clock

Minutes. Business. Selection of Nominating Committee.

9:30 to 10:00 O'Clock

Clinical and Etiologic Studies in Hodgkin's Granuloma

HERMAN A. HOSTER, M.D., Columbus.

10:00 to 10:30 O'Clock

Use of Thiouracil in Patients With Hyperthyroidism

J. HAROLD KOTTE, M.D., Cincinnati.

10:30 to 11:00 O'Clock

Penicillin: Indications and Methods of Administration

ROBERT F. PARKER, M.D., Cleveland.

11:00 to 12:00 O'Clock

Quiz-Discussion Session

Moderator: Frank M. Wiseley, M.D., Findlay.

Discussants: Homer F. Swift, M.D., New York, N.Y.; Walter L. Palmer, M.D., Chicago, Ill.; Carl V. Moore, M.D., St. Louis, Mo.; William H. Feldman, D.V.M., D.Sc., Rochester, Minn.; W. J. Zeiter, M.D., Cleveland.

Election of Officers.

Adjournment for Inspection of Exhibits.

WEDNESDAY MORNING, MAY 8

9:00 O'Clock

SECTION ON EYE, EAR, NOSE AND THROAT

Meeting Place—Room 1540, Deshler-Wallick Hotel

HARRY C. ROSENBERGER, M.D., Cleveland.....*Chairman*
EDWARD R. THOMAS, M.D., Dayton.....*Secretary*

9:00 to 9:30 O'Clock

Minutes. Business. Selection of Nominating Committee.

9:30 to 9:45 O'Clock

The Fenestration Operation in the Treatment of Deafness (Report of 100 Cases)

HAROLD E. HARRIS, M.D., Cleveland.

9:45 to 10:00 O'Clock

Relation of the Diseases of the Paranasal Sinuses to Affections of the Optic Nerve

ALBERT L. BROWN, M.D., Cleveland.

10:10 to 10:15 O'Clock

Physiological and Pathological Findings of the Nasopharynx When Viewed Through the Nasal Pharyngoscope

HARRY H. HAGGART, M.D., Cincinnati.

10:15 to 10:30 O'Clock

Diagnosis of Visual Losses With Normal Fundus

DONALD J. LYLE, M.D., Cincinnati.

10:30 to 10:45 O'Clock

Vagal-Recurrent Anastomosis for Recurrent Laryngeal Nerve Paralysis

J. W. MCCALL, M.D., Cleveland.

10:45 to 11:00 O'Clock

Eye Changes in Relation to Intracranial Lesions

A.D. RUEDEMANN, M.D., Cleveland.

11:00 to 12:00 O'Clock

Quiz-Discussion Session

Moderator: Harry C. Rosenberger, M.D., Cleveland.

Discussants: Harold E. Harris, M.D., Cleveland; Albert L. Brown, M.D., Cincinnati; Harry H. Haggart, M.D., Cincinnati; Donald J. Lyle, M.D., Cincinnati; J. W. McCall, M. D., Cleveland; A. D. Ruedemann, M.D., Cleveland; Arthur Culler, M.D., Columbus; Henry Goodyear, M.D., Cincinnati.

Election of Officers.

Adjournment for Inspection of Exhibits.

WEDNESDAY MORNING, MAY 8

9:00 O'Clock

SECTION ON OBSTETRICS AND GYNECOLOGY

Meeting Place—Red Room, Mezzanine Floor, Neil House

M. D. Haag, M.D., Toledo.....*Chairman*
R. D. Dooley, M.D., Dayton.....*Secretary*

9:00 to 9:30 O'Clock

Minutes. Business. Selection of Nominating Committee.

9:30 to 9:50 O'Clock

Critical Analysis of 250 Deliveries Under Caudal Analgesia

Jos. H. Prince, M.D., Dayton.

9:50 to 10:10 O'Clock

Early Ambulation in Obstetrics

Chas. W. Pavey, M.D., Columbus.

10:10 to 10:30 O'Clock

The Management of Threatened Abortion

Wynne M. Silbernagel, M.D., Columbus.

10:30 to 10:50 O'Clock

Treatment of the Uterine Prolapse Syndrome by the Spalding-Richardson Composite Procedure

Robert C. Austin, M.D., Dayton.

11:00 to 12:00 O'Clock

Quiz-Discussion Session

Moderator: M. D. Haag, M.D., Toledo.

Discussants: Allan C. Barnes, M.D., Columbus; H. L. Woodward, M.D., Cincinnati.

Election of Officers.

Adjournment for Inspection of Exhibits.

WEDNESDAY MORNING, MAY 8

9:00 O'Clock

OHIO SOCIETY OF ANESTHETISTS

Meeting Place—Room 1440, Deshler-Wallick Hotel

J. H. CALDWELL, M.D., Warren.....*President*

B. B. SANKEY, M.D., Cleveland.....*Secretary-Treasurer*

9:00 to 9:30 O'Clock

War Advances Anesthesia

K. C. MCCARTHY, M.D., Toledo.

9:30 to 10:15 O'Clock

Cyclopropane Anesthesia: An Evaluation of Ten Years' Experience

A. A. BRINDLEY, M.D., Toledo.

10:15 to 11:00 O'Clock

Practical Concepts in Anesthesia

EDWARD B TUOHY, M.D., Rochester, Minn.,
Section on Anesthesiology, Mayo Clinic; Associate Professor of Anesthesiology, University of Minnesota; President-Elect of American Society of Anesthesiology.

11:00 to 12:00 O'Clock

Spinal Anesthesia (Panel Discussion)

Moderator: R. J. Whitacre, M.D., Cleveland.

Discussants: Edward B. Tuohy, M.D., Rochester, Minn.; K. C. McCarthy, M.D., Toledo; N. E. Lenahan, M.D., Columbus; J. K. Potter, M.D., Cleveland; B. B. Sankey, M.D., Cleveland.

12:00 O'Clock Noon

Business Meeting and Election of Officers.

Adjournment for Inspection of Exhibits.

WEDNESDAY MORNING, MAY 8

9:00 O'Clock

OHIO STATE RADIOLOGICAL SOCIETY

Meeting Place—Room 1337, Deshler-Wallick Hotel

C. E. HUFFORD, M.D., Toledo.....*President*

HENRY SNOW, M.D., Dayton.....*Secretary*

9:15 to 10:30 O'Clock

General Session

Chairman: U. V. Portmann, M.D., Cleveland.

Work of the Council on Medical Service and Public Relations

E. J. MCCORMICK, M.D., Toledo,
Chairman of A.M.A. Council on Medical Service and Public Relations.

American Medicine Tomorrow

MAC F. CAHAL, Chicago, Ill.,
Executive Secretary of The American College of Radiology.

10:30 to 12:00 O'Clock

Film Demonstration and Discussion

Chairman: E. C. Baker, M.D., Youngstown.

12:30 to 2:00 O'Clock

Business Session and Luncheon in Parlors H and I, Deshler-Wallick Hotel.

WEDNESDAY MORNING, MAY 8

9:00 O'Clock

OHIO SOCIETY OF PATHOLOGISTS

Meeting Place—Dept. of Pathology, Hamilton Hall, Ohio State University

W. D. Collier, M.D., Youngstown.....*President*
A. H. Schade, M.D., Toledo.....*Secretary*

1. Presentation of Case and Scientific Reports

Members of Dept. of Pathology, Ohio State University.

2. Slide Library

3. Business Meeting

WEDNESDAY AFTERNOON, MAY 8

12:15 O'Clock

SECTION ON NERVOUS AND MENTAL DISEASES

Meeting Place—Garden Room, Mezzanine Floor, Neil House

Luncheon

Informal Discussions:

Brigadier General William C. Menninger, Washington, D.C., Director, Neuropsychiatry Consultants Division, Office of the Surgeon General, United States Army; medical director of the Menninger Psychiatric Hospital, Topeka, Kans.

Frank F. Tallman, M.D., Columbus, Commissioner of Mental Hygiene, Ohio Department of Public Welfare.

WEDNESDAY AFTERNOON, MAY 8

12:15 O'Clock

OHIO CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

Coral Room, Mezzanine Floor, Neil House.

R. C. McKay, M.D., Cleveland.....*Vice-President*
E. E. Kirkwood, M.D., Youngstown.....*Secretary-Treasurer*

Luncheon

Tuberculosis in Ohio Mental Institutions

Mark W. Garry, M.D.,
Chief, Division of Tuberculosis, Ohio Department of Health.

WEDNESDAY AFTERNOON, MAY 8

2:00 O'Clock

THIRD GENERAL SESSION

Meeting Place—Main Ballroom, Mezzanine Floor, Neil House

LOUIS G. HERRMANN, M.D., Cincinnati, Member of Committee on Scientific Work, presiding.

2:00 to 2:30 O'Clock

Medical Management of Gastro-Intestinal Disturbances

WALTER L. PALMER, M.D., Chicago, Ill.,
Professor of Medicine, University of Chicago, School of Medicine.

2:30 to 3:00 O'Clock

The Surgical Treatment of Bleeding Peptic Ulcer and Gastric Cancer

ROY D. MCCLURE, M.D., Detroit, Mich.,
Chief Surgeon, Henry Ford Hospital, Detroit.

3:00 to 3:30 O'Clock

Recent Advances in the Understanding and Therapy of Anemias

CARL V. MOORE, M.D., St. Louis, Mo.,
Associate Professor of Medicine, Washington University School of Medicine, St. Louis, Mo.

3:30 to 3:45 O'Clock

Recess to Visit Exhibits.

3:45 to 4:15 O'Clock

Evidence of Therapeutic Effects of Streptomycin in Experimental Tuberculosis

WILLIAM H. FELDMAN, D.V.M., D.Sc., Rochester, Minn.,
Associate Professor of Comparative Pathology, Mayo Foundation of Graduate School, University of Minnesota, Rochester, Minn.

4:15 to 4:45 O'Clock

Immunization in Infectious Diseases

CHARLES F. MCKHANN, M.D., Cleveland.

4:45 to 5:15 O'Clock

Readjustment of the Disabled Veteran to Civilian Life

BRIGADIER GENERAL WILLIAM C. MENNINGER, Washington, D.C.,
Director, Neuropsychiatry Consultants Division, Office of The Surgeon General, United States Army; Medical Director of the Menninger Psychiatric Hospital, Topeka, Kans.

Adjournment for Inspection of Exhibits.

WEDNESDAY EVENING, MAY 8

7:00 O'Clock

CENTENNIAL ANNIVERSARY BANQUET

Main Ballroom, Mezzanine Floor, Neil House

L. Howard Schriver, M.D., Cincinnati, President, Ohio State Medical Association, *Toastmaster.*

Introduction of Incoming President and New President-Elect

Introduction of Officers, Councilors, and Distinguished Guests

Introduction of Past-Presidents

Presentation of Past-President's Gavel

Address: Forever As He Rides

Philip D. Jordan, Ph.D., Minneapolis, Minn.,
Associate Professor of History, University of Minnesota; formerly Associate Professor of History, Miami University, Oxford, Ohio.

THURSDAY MORNING, MAY 9

9:00 O'Clock

SECTION ON SURGERY

Meeting Place—Main Ballroom, Mezzanine Floor, Neil House

Wm. Kelley Hale, M.D., Wilmington.....*Chairman*
J. Edwin Purdy, M.D., Canton.....*Secretary*

9:00 to 9:30 O'Clock

Minutes. Business. Selection of Nominating Committee.

9:30 to 9:45 O'Clock

Tumors of the Small Intestine

Carroll C. Dundon, M.D., Cleveland.

9:45 to 10:00 O'Clock

The Management of Fractures of the Humerus

John A. Caldwell, M.D., Cincinnati.

10:00 to 10:15 O'Clock

The Indications for Splenectomy

George M. Curtis, M.D., Columbus.

10:15 to 10:30 O'Clock

Transthoracic Resection of Esophagus and Stomach for Esophageal Obstruction

Frederick R. Mautz, M.D., Cleveland.

10:30 to 10:45 O'Clock

Cancer of the Breast

E. J. McCormick, M.D., Toledo.

11:00 to 12:00 O'Clock

Quiz-Discussion Session

Moderator: Thomas E. Jones, M.D., Cleveland.

Discussants: Roy D. McClure, M.D., Detroit, Mich.; Stanley P. Reimann, M,D., Philadelphia, Pa.; Vinton E. Siler, M.D., Cincinnati.

Election of Officers.

THURSDAY MORNING, MAY 9

9:00 O'Clock

SECTION ON PEDIATRICS

Meeting Place—Victory Room, Lobby Floor, Neil House

James G. Kramer, M.D., Akron.....*Chairman*
Samuel Edelman, M.D., Columbus.....*Secretary*

9:00 to 9:30 O'Clock

Minutes. Business. Selection of Nominating Committee.

9:30 to 9:50 O'Clock

The Prevention of Rheumatic Fever in Children

Robert A. Lyon, M.D., Cincinnati.

9:50 to 10:10 O'Clock

The Use of Parenteral Fluids in Infants

E. H. Baxter, M.D., Columbus.

10:10 to 10:30 O'Clock

Vomiting and Diarrhea in Infants

Charles F. McKhann, M.D., Cleveland.

10:30 to 10:50 O'Clock

Evaluation of Nutrition in Childhood

Chauncey W. Wyckoff, M.D., Cleveland.

11:00 to 12:00 O'Clock

Quiz-Discussion Session

Moderator: James G. Kramer, M.D., Akron.

Discussants: Charles F. McKhann, M.D., Cleveland; Robert A. Lyon, M.D., Cincinnati; E. H. Baxter, M.D., Columbus; Chauncey W. Wyckoff, M.D., Cleveland.

Election of Officers.

THURSDAY MORNING, MAY 9

9:00 O'Clock

SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE

Meeting Place—Room 1540, Deshler-Wallick Hotel

CARL A. WILZBACH, M.D., Cincinnati.....*Chairman*

W. D. BISHOP, M.D., Greenville.....*Secretary*

9:00 to 9:30 O'Clock

Minutes. Business. Selection of Nominating Committee.

9:30 to 10:00 O'Clock

Problems of Tuberculosis Control

MARK W. GARRY, M.D., Columbus.

10:00 to 10:30 O'Clock

Responsibility in Venereal Disease Control

ROGER E. HEERING, M.D., Columbus.

10:30 to 11:00 O'Clock

What the Doctor Should Know About Housing and Health

BLEECKER MARQUETTE, Cincinnati.

11:00 to 12:00 O'Clock

Quiz-Discussion Session

Moderator: W. D. BISHOP, M.D., Greenville.

Discussants: Mark W. Garry, M.D., Columbus; Roger E. Heering, M.D., Columbus; Bleecker Marquette, Cincinnati; and Harry Wain, M.D., Troy.

Election of Officers.

THURSDAY MORNING, MAY 9

9:00 O'Clock

SECTION ON NERVOUS AND MENTAL DISEASES

Meeting Place—Room 1337, Deshler-Wallick Hotel

JOHN M. WITTENBROOK, M.D., Cleveland.....*Chairman*

E. H. CRAWFIS, M.D., Cleveland.....*Secretary*

9:00 to 9:15 O'Clock

Minutes. Business. Election of Officers.

9:15 to 9:45 O'Clock

Some Reflections on Psychosomatic Medicine

R. E. PINKERTON, M.D., Akron.

Discussant: Guy H. Williams, Jr., M.D., Cleveland.

9:45 to 10:15 O'Clock

Idiopathic Epilepsy: Diagnosis and Treatment

ELMER HAYNES, M.D., Toledo.

Discussant: E. M. Zucker, M.D., Cleveland.

10:15 to 10:45 O'Clock

Schizophrenic Children

HENRY C. SCHUMACHER, M.D., Cleveland.

Discussant: Louis A. Lurie, M.D., Cincinnati.

10:45 to 11:30 O'Clock

Quiz-Discussion Session on Electric Shock Therapy

Discussants: J. L. Fetterman, M.D., Cleveland; Edgar L. Braunlin, M.D., Dayton; Charles Anderson, M.D., Columbus; Nicholas Michael, M.D., Columbus.

11:30 to 12:00 O'Clock

General Quiz-Discussion Session

Open for general discussion and questions on subjects other than electric shock therapy.

Moderator: John M. Wittenbrook, M.D., Cleveland.

Discussants: R. E. Pinkerton, M.D., Akron; Elmer Haynes, M.D., Toledo; Henry C. Schumacher, M.D., Cleveland.

DELEGATES AND ALTERNATES

Counties	*Delegates*	*Alternates*
ADAMS	S. J. Ellison	R. B. Ellison
ALLEN	J. R. Johnson	Burt Hibbard
ASHLAND	Geo. M. Emery	H. M. Gunn
ASHTABULA	R. B. Wynkoop	P. J. Collander
ATHENS	H. H. Fockler	L. A. Hamilton
AUGLAIZE	R. C. Hunter	Elizabeth Y. Kuffner
BELMONT	J. B. Martin	E. V. Arbaugh, Jr.
BROWN	R. B. Hannah	Geo. P. Tyler, Jr.
BUTLER	Chas. T. Atkinson	Harry M. Lowell
CARROLL	W. G. Lyle	Lewis W. Cellio
CHAMPAIGN	D. C. Houser	Mark C. Houston
CLARK	D. W. Hogue	Ray M. Turner
CLERMONT	Pearl Zeek-Minning	J. M. Coleman
CLINTON	Robert Conard	J. H. Frame
COLUMBIANA	J. A. Fraser	J. W. Schoolnic
COSHOCTON	G. A. Foster	F. W. Craig
CRAWFORD	D. G. Arnold	E. R. Schoolfield
CUYAHOGA	F. T. Gallagher	C. A. Swan
	R. B. Crawford	R. J. Whitacre
	Robert F. Parker	J. H. Lazzari
	A. B. Bruner	John H. Budd
	M. Paul Motto	P. A. Mielcarek
	James N. Wychgel	Irving M. Liebow
	D. M. Keating	Donald C. Darrah
	C. G. LaRocco	William Fornes
	Fay A. LeFevre	J. M. Rossen
	R. M. Watkins	W. H. Pritchard
	James E. Hallisy	
	J. W. Conwell	

DELEGATES AND ALTERNATES

Counties	*Delegates*	*Alternates*
DARKE	J. E. Gillette	P. G. Lenhert
DEFIANCE	D. J. Slosser	Paul B. Newcomb
DELAWARE	M. W. Livingston	F. V. Miller
ERIE	V. A. Killoran	E. J. Meckstroth
FAIRFIELD	C. P. Swett	Leo Stenger
FAYETTE	J. H. Persinger	A. D. Woodmansee
FRANKLIN	James A. Beer	H. R. Mitchell
	I. B. Harris	Roy J. Secrest
	Chas. W. Pavey	George F. Collins
	F. C. Hugenberger	John B. Gravis
	Drew L. Davies	John J. Gallen
	George J. Heer	W. L. Pritchard
FULTON	L. C. Cosgrove, Sr.	A. M. Wilkins
GALLIA	F. W. Shane	Paul C. Foster
GEAUGA	H. E. Shafer	W. A. Reed
GREENE	C. G. McPherson	P. D. Espey
GUERNSEY	Earl E. Conaway	J. A. L. Toland
HAMILTON	E. A. Kindel	C. Ross Deeds
	Lloyd B. Johnston	Harry L. Fry
	H. H. Shook	Edward J. McGrath
	Louis B. Owens	Richard S. Tyler
	Harold F. Downing	Louis J. Hendricks
	Donald J. Lyle	A. R. Vonderahe
	William J. Graf	Joseph G. Crotty
	D. W. Heusinkveld	A. Clyde Ross
	Emil R. Swepston	Vinton E. Siler
HANCOCK	Frank M. Wiseley	R. S. Rilling
HARDIN	H. A. Kerns	F. M. Elliott
HARRISON	Carl F. Goll	Richard W. Weiser
HENRY	J. R. Bolles	Thomas Quinn
HIGHLAND		
HOCKING	Charles F. Shonk	C. T. Grattidge
HOLMES	A. T. Cole	J. C. Elder
HURON	H. C. Sparks	George F. Linn
JACKSON	Marlin W. Wedemeyer	G. A. Parry
JEFFERSON	Earl Rosenblum	John F. Gallagher
KNOX	Geo. B. Imhoff	C. L. Harmer
LAKE	M. G. Carmody	G. R. Smith
LAWRENCE	Geo. G. Hunter	H. W. Johnson
LICKING	Arthur J. Tronstein	J. Fleek Miller
LOGAN	Charles L. Barrett	F. Blair Webster
LORAIN	Charles R. Meek	Valloyd Adair
	S. V. Burley	Geo. D. Nicholas
LUCAS	F. N. Nagel	Foster Myers
	R. C. Young	H. F. Lowe
	M. R. Lorenzen	A. L. Bershon
	Carll S. Mundy	Oliver Todd
MADISON	J. W. Hurt	G. C. Scheetz
MAHONING	E. J. Wenaas	E. C. Baker
	John N. McCann	J. J. McDonough
	Wm. M. Skipp	W. J. Tims
MARION	J. A. McNamara	R. L. Morgan
MEDINA	N. J. M. Klotz	R. F. Fasoli
MEIGS	R. E. Boice	W. S. Ellis
MERCER	Rudolph Schmidt	E. J. Willke
MIAMI	G. A. Woodhouse	J. E. Bausman
MONROE		
MONTGOMERY	R. S. Binkley	R. K. Bartholomew
	M. R. Haley	L. E. Baker
	M. D. Prugh	Ned D. Shepard
	R. D. Dooley	
MORGAN	A. H. Whitacre	C. E. Northrup
MORROW	J. P. Ingmire	F. M. Hartsook
MUSKINGUM	M. A. Loebell	C. F. Sisk

DELEGATES AND ALTERNATES

Counties	*Delegates*	*Alternates*
NOBLE		
OTTAWA	George A. Boon	Harry O. Beeman
PAULDING	D. E. Farling	
PERRY	James Miller	E. D. Allen
PICKAWAY	E. S. Shane	A. D. Blackburn
PIKE	Robert T. Leever	L. E. Wills
PORTAGE	Myron S. Owen	Myron W. Thomas
PREBLE	G. W. Flory	F. M. Hearst
PUTNAM	H. N. Trumbull	H. A. Neiswander
RICHLAND	John S. Hattery	J. F. McHugh
ROSS	Ralph W. Holmes	O. P. Tatman
SANDUSKY	J. L. Curtin	E. C. Swint
SCIOTO	D. A. Berndt	W. A. Quinn
SENECA	R. F. Machamer	Paul J. Leahy
SHELBY	H. C. Clayton	C. B. Conover
STARK	A. R. Basinger	Graydon Underwood
	John M. Van Dyke	R. L. Clunk
SUMMIT	C. R. Steinke	J. T. Cunningham
	J. T. Villani	A. V. Gold
	V. C. Malloy	W. A. Keitzer
	R. E. Pinkerton	Kurt Weidenthal
TRUMBULL	R. D. Herlinger	D. L. Beers
TUSCARAWAS	Jay W. Calhoon	B. O. Burkey
UNION	Evert J. Marsh	Herman C. Duke
VAN WERT	O. J. Fatum	H. D. Underwood
VINTON	H. D. Chamberlain	Harold Carter
WARREN	Robt. M. Wilson	A. E. Stout
WASHINGTON	W. E. Radcliff	J. A. McCowan
WAYNE	F. C. Ganyard	R. C. Paul
WILLIAMS	H. W. Wertz	R. K. Ameter
WOOD	Earl D. Foltz	R. W. Whitehead
WYANDOT	J. Craig Bowman	F. M. Smith

OFFICERS

President.....L. HOWARD SCHRIVER
President-Elect.....EDGAR P. MCNAMEE
Treasurer Pro-Tem....JOHN H. MITCHELL
Past-President.....C. C. SHERBURNE

COUNCILORS

District		*District*	
First	E. O. Swartz	Sixth	R. L. Rutledge
Second	H. C. Messenger	Seventh	Carl A. Lincke
Third	Guy E. Noble	Eighth	George F. Swan
Fourth	A. A. Brindley	Ninth	Gilbert Micklethwaite
Fifth	Fred W. Dixon	Tenth	H. M. Clodfelter
		Eleventh	Ross M. Knoble

TECHNICAL EXHIBITORS

Mezzanine Lounge and Junior Ballroom, Neil House

Open from 9:00 A.M. to 6:00 P.M. on May 7-8; from 9:00 A.M. to 12:00 Noon, May 9.

Exhibitor	Address	Booth No.
Abbott Laboratories	North Chicago, Ill.	50
Aloe Company, A. S.	St. Louis, Mo.	10, 11
Ames Company, Inc.	Elkhart, Ind.	46
Ayerst, McKenna & Harrison, Ltd.	New York, N.Y.	41

TECHNICAL EXHIBITORS

Exhibitor	Address	Booth No.
Baker Laboratories, The	Cleveland, Ohio	7
Bilhuber-Knoll Corp.	Orange, N.J.	16
Borden Company, The	New York, N.Y.	42
Bowman Bros. Drug Co., The	Canton, Ohio	32
Burke Garringer, X-Ray Sales Co.	Cleveland Ohio	17
Burroughs Wellcome & Co. Inc.	New York, N.Y.	44
Camel Cigarettes	New York, N.Y.	23, 24
Cameron Surgical Specialty Co.	Chicago, Ill.	5
Ciba Pharmaceutical Products, Inc.	Summit, N.J.	57
Coca-Cola Company, The	Atlanta, Ga.	29, 30
Columbus Hospital Supply Co.	Columbus, Ohio	27, 28
Denver Chemical Mfg. Co., Inc., The	New York, N.Y.	19
DePuy Manufacturing Company	Warsaw, Ind.	18
Endo Products, Inc.	Richmond Hill, N.Y.	45
Fidelity Medical Supply Company, The	Dayton, Ohio	36
Heinz Company, H. J.	Pittsburgh, Pa.	52
Holland-Rantos Company, Inc.	New York, N.Y.	2
"'Junket' Folks, The"	Little Falls, N.Y.	33
Kelley-Koett Manufacturing Co., The	Covington, Ky.	53
Lea & Febiger	Philadelphia, Pa.	6
Lederle Laboratories, Inc.	New York, N.Y.	40
Liebel-Flarsheim Company, The	Cincinnati, Ohio	26
Lilly and Company, Eli	Indianapolis Ind.	62
Lippincott Co., J. B.	Philadelphia, Pa.	60
M & R Dietetic Laboratories, Inc.	Columbus, Ohio	12
Mead Johnson & Company	Evansville, Ind.	48, 49
Medical Protective Company, The	Fort Wayne, Ind.	47
Merrell Company, Wm. S., The	Cincinnati, Ohio	25
Mosby Company, C. V., The	St. Louis, Mo.	8
Parke, Davis & Company	Detroit, Mich.	22
Pelton & Crane Company, The	Detroit, Mich.	43
Philip Morris & Co., Ltd., Inc.	New York, N.Y.	9
Picker X-Ray Corporation	Cleveland, Ohio	38, 39
Pitman-Moore Company	Indianapolis, Ind.	20, 21
Proctor & Gamble Company, The	Ivorydale, Ohio	37
Radium Emanation Corporation, The	New York, N.Y.	13
Saunders Company, W. B.	Philadelphia, Pa.	1
Schenley Laboratories, Inc.	New York, N.Y.	58
Schering Corporation	Bloomfield, N.Y.	34
Schuemann Jones Co., The	Cleveland, Ohio	4
Searle & Company, G. D.	Chicago, Ill.	59
Spencer, Incorporated	New Haven, Conn.	35
Squibb & Sons, E. R.	New York, N.Y.	14
Stearns & Company Division, Frederick	Detroit, Mich.	61
Walker Vitamin Products, Inc.	Mt. Vernon, N.Y.	55
Warren-Teed Products Co., The	Columbus, Ohio	3
Wendt-Bristol Co., The	Columbus, Ohio	15
White Laboratories, Inc.	Newark, N.J.	56
White-Haines Optical Company, The	Columbus, Ohio	31
Winthrop Chemical Company, Inc.	New York, N.Y.	54
Wocher & Son Company, The Max	Cincinnati, Ohio	51

WOMAN'S AUXILIARY ANNUAL MEETING

Deshler-Wallick Hotel, May 7, 8, and 9, 1946

Mrs. Ralph W. Hoffman, Columbus
General Chairman

TUESDAY MORNING, MAY 7

11:00 O'Clock

Parlor G, Wallick Addition

Registration.

12:00 O'Clock Noon

Parlor J, Wallick Addition

Pre-Convention Board Meeting.

TUESDAY AFTERNOON, MAY 7

3:00 O'Clock

Hall of Mirrors, Wallick Addition

First Business Session, House of Delegates.

Call to Order
Greetings to the Convention
Response for the Convention
Organization of the Convention

Report of the President
Report of the Secretary
Report of the Treasurer
Reports of District Directors and County Auxiliary Presidents

TUESDAY EVENING MAY 7

7:00 O'Clock

Hall of Mirrors, Wallick Addition

Buffet Supper for Officers, Delegates, Directors, and Guests.

8:30 O'Clock

Hall of Mirrors, Wallick Addition

Reception and Musical in Honor of County Auxiliary Presidents.

WEDNESDAY MORNING, MAY 8

7:45 O'Clock

Parlor J, Wallick Addition

Breakfast.

Address: National Health Program of A.M.A.

E. J. McCormick, M.D., Toledo.
Chairman, Council on Medical Service and Public Relations,
American Medical Association.

9:00 to 11:00 O'Clock

Parlor G, Wallick Addition

Registration.

9:30 O'Clock

Hall of Mirrors, Wallick Addition

Second Business Session, House of Delegates.

Reports of Committees.

WEDNESDAY AFTERNOON, May 8

1:00 O'Clock

Hall of Mirrors, Wallick Addition

President's Luncheon.

Address: One Hundred Years of Organized Medicine in Ohio

JONATHAN FORMAN, M.D., Columbus,
Editor, The Ohio State Medical Journal.

2:30 O'Clock

Hall of Mirrors, Wallick Addition

Third Business Session, House of Delegates.

Reports of Committees.

WEDNESDAY EVENING, MAY 8

7:00 O'Clock

Neil House, Main Ballroom, Mezzanine Floor

Centennial Anniversary Banquet of Ohio State Medical Association.

THURSDAY MORNING MAY 9

9:00 O'Clock

Parlors H, I, J, Wallick Addition

Fourth Business Session, House of Delegates.

Unfinished Business

Election by House of Delegates

Installation of Officers

12:00 O'Clock Noon

Luncheon Honoring New President.

Address: Mrs. Doctor in the Community

DISCUSSION BY SIX AUXILIARY MEMBERS.

THURSDAY AFTERNOON, MAY 9

2:45 O'Clock

Headquarters Suite

Post-Convention Board Meeting.

AUXILIARY OFFICERS, DIRECTORS, AND COMMITTEE CHAIRMEN

President—Mrs. R. S. Fidler, Columbus.

President-Elect—Mrs. Paul A. Davis, Akron.

Past-President—Mrs. J. L. Stevens, Mansfield.

Vice-President—Mrs. C. M. Fitch, Portsmouth.

Secretary—Mrs. David Heusinkveld, Cincinnati.

Treasurer—Mrs. Dean Nesbit, Youngstown.

Directors—Mrs. W. B. Roads, Hillsboro; Mrs. K. F. Lowry, Troy; Mrs. Claude Lingenfelter, Bucyrus; Mrs. Paul M. Holmes, Toledo; Mrs. John Phillips, Cleveland; Mrs. J. J. McDonough, Youngstown; Mrs. C. J. Miller, New Philadelphia; Mrs. Richard H. Sloan, Marietta; Mrs. W. M. Singleton, Portsmouth; Mrs. George W. Cooper, Clarksburg; Mrs. C. H. Bell, Mansfield.

Chairmen of Standing Committees—Finance—Mrs. J. L. Stevens, Mansfield. *Publicity*—Mrs. Fred W. Brosius, Middletown, *Hygeia*—Mrs. Harold R. Mouser, Marion. *Program*—Mrs. George Wilcoxon, Alliance. *Legislation*—Mrs. W. Frank Maxwell, Toledo. *Public Relations*—Mrs. Emerson Gillespie, Canton. *Historical*—Mrs. Lewis L. Liggett, St. Clairsville. *Organization*—Mrs. Paul A. Davis, Akron. *Convention*—Mrs. Ralph W. Hoffman, Columbus.

Chairmen of Special Committees—Nurses' Scholarship Loan Fund—Mrs. Ralph W. Hoffman, Columbus. *Revisions*—Mrs. Dale P. Osborn, Cincinnati. *Bulletin and Handbook*—Mrs. Frank A. Riebel, Columbus.

Golf Tournament To Be Held In Columbus, May 6, Day Preceding 1946 Annual Meeting of Association

THE Ohio State Medical Golfers' Association will hold a tournament in Columbus on Monday, May 6, the day preceding the Centennial Anniversary Meeting of the Ohio State Medical Association.

The place of the tournament has not been selected as yet, but Dr. William B. Morrison, who is heading the Columbus golf committee, has definite assurance from several Columbus country clubs that their courses will be available.

Selection of the place will be made soon and detailed information will be sent to all Ohio physicians who have participated in past tournaments.

This social feature of the Annual Meeting had to be shelved during the war.

Those interested in securing details about the golf tournament, and who do not receive a special announcement, should communicate with Mr. George Cooley, secretary of the Golfers' Association, Toledo Academy of Medicine, Monroe at Fifteenth, Toledo 2.

QUESTIONS . . . . . .

● Which you want answered at the Quiz-Discussion Hour which will conclude the session of each Scientific Section at the 1946 Annual Meeting, Ohio State Medical Association, May 7, 8, and 9, Columbus, should be submitted immediately.

The final hour of the session of each Scientific Section will be devoted to Questions and Answers.

The guest speakers as well as Ohio physicians will constitute the panels for this program feature.

USE THIS BLANK FOR YOUR QUESTION

Ohio State Medical Association
79 East State Street
Columbus 15, Ohio

I would like to have the following question discussed during the Quiz-Discussion Session of the meeting of the Section on.....

(See Official Program, this issue, for list of sections and meeting dates.)

Question: _____

_____

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Annual Reports of Standing and Special Committees of the Ohio State Medical Association

PRESENTED herewith are reports on the activities of committees of the Ohio State Medical Association which have transacted business since the Annual Meeting of the Association in May, 1944. Since no meeting was held in 1945 because of wartime transportation problems, these reports will cover a period of two years.

The Council suggests that all members read these reports carefully. There is no better way for them to obtain an insight into the many and diversified activities of the officials and committees of the State Association than through reviewing the work of the committees.

The committee reports also reflect some of the work of The Council as many of the Council activities are based on interim reports and recommendations of the various committees.

Because of restrictions resulting from wartime conditions, some of the State Association committees have not attempted any new activities for the past several years but expect to resume their work as conditions permit.

On the other hand, several of the committees have carried an unusually heavy load and have completed some historic achievements for medical organization in Ohio.

To those members of the state committees who have worked so faithfully and sacrificed so much in time and effort, The Council expresses its sincere appreciation. Moreover, The Council desires to thank the officers and committeemen of all County Medical Societies for their fine cooperation and assistance during the past two years.

Conditions are becoming more normal. This means that medical organization in Ohio, state and local, must step up its activities in order that it may be in a strong position to meet new and old public problems affecting medicine and to better serve its members. This presents a real challenge to the officials of the State Association and to local medical societies as well as to members, individually and collectively. As The Council has stated on previous occasions, medical organization is merely a federation of individuals. It can be, and will be, as strong as its members see fit to make it.

The Council,
Ohio State Medical Association.

REPORT OF COMMITTEE ON PUBLIC RELATIONS AND ECONOMICS

A vast amount of work was performed by the Committee on Public Relations and Economics during the past 24 months. Most of the activities of the committee have been reported from time to time to The Council and referred to in the minutes of meetings of The Council, published in *The Ohio State Medical Journal.* Nevertheless, résumés of some of the important matters considered by the committee will be presented.

In the Fall of 1944 the committee, assisted by its Sub-Committee on Legislation and local legislative committees, made a careful check of the qualifications of candidates for the Ohio General Assembly and the U. S. Congress standing for election in the General Election in November. This information was disseminated to the membership generally through the local committees.

Between January 1, 1945, and July of the same year, the committee, again assisted by the state and local legislative committees, took an active interest in the affairs of the 96th Ohio General Assembly. Some 50 measures introduced into the State Legislature pertained to health or medical questions. On these, the opinions of the State Association were expressed through official representatives of the Association. No bills detrimental to public health or to medical standards were enacted. A number of proposals of definite value to public health and supported by the State Association were passed. Actions taken by the General Assembly on medical, health, and welfare proposals were reviewed in an article published in the August, 1945, issue of *The Ohio State Medical Journal* which should be considered as a part of this report.

FEDERAL PROPOSALS

Also, the committee maintained an active interest in the affairs of the U. S. Congress. Official expressions of opposition to the Wagner-Murray-Dingell Compulsory Sickness Insurance Bill were transmitted to the Ohio members of the Congress. Some 500,000 pamphlets setting forth the policy of the State Association with respect to that measure and similar bills were distributed to the citizens of Ohio. Many speaking engagements on the subject were filled by officials and committeemen of the State Associa-

tion and of the County Medical Societies, and by members of the Columbus office staff.

The committee also played an active part in presenting to Ohio's members of the Congress strong appeals for the early release of medical officers after V-E Day and again following the surrender of Japan. As a result of these appeals and those from other states, demobilization of medical officers was speeded up. However, despite these efforts, the demobilization of medical officers has been woefully slow and the belief still persists that the armed forces are retaining more medical officers than they need under present conditions.

PROPOSED NATIONAL HEALTH PLAN

Late in 1945, President Truman in a special message to the Congress presented a so-called National Health Program which included an appeal for enactment of a compulsory sickness insurance law. Bills, S. 1606 and H.R. 4730, to implement the Truman program, were introduced by Senators Wagner and Murray and Congressman Dingell. On recommendation of this committee, The Council has voiced the official opposition of the State Association to many of the features of these bills, including the compulsory sickness insurance provision. This information has been transmitted to Ohio's Senators and Congressmen and the committee, at this writing, is preparing to mobilize the resources of the State Association in opposition to the enactment of these measures.

Moreover, The Council, on recommendation of the committee, has officially opposed enactment of the so-called Pepper Bill, S. 1318, which would establish a national program to provide maternal and child health services to all mothers and children, regardless of need—a continuation of the E.M.I.C. program on an enlarged scale. Active opposition to this proposal also is being organized under the guidance of this committee, its Sub-Committee on Legislation and local committeemen.

HOSPITAL BUILDING PLAN ENDORSED

A Federal proposal of importance, S. 191, the Hill-Burton hospital building measure, has been endorsed in principle by the State Association and action supporting its enactment has been taken.

Also, the committee supported the recently-enacted proposal calling for a reorganization and modernization of the Veterans Administration.

The 14-point program established by the American Medical Association for extension of health services has had the endorsement of the State Association. Through publication of this information in *The Journal* and through references in special bulletins, the committee has urged all local medical societies to take immediate steps to carry out the suggestions of the A.M.A. program on a local basis, whenever and wherever feasible.

OHIO PROGRAMS SUPPORTED

Two Ohio programs of state-wide importance have had the active support of the committee; namely: Plans and legislation to expand and modernize the state's mental hygiene program; and the present campaign to improve Ohio's tuberculosis control program through proposed legislation to be acted upon by the next General Assembly.

Federal proposals calling for elimination of stream pollution in the Ohio River Valley have been endorsed and follow-up action with members of the Congress has been taken.

Active cooperation and assistance have been given to the Ohio Department of Education on matters regarding health education and health and medical programs in the schools. Recommendations submitted by the committee on both phases of this activity of the department were accepted by it.

At the request of the Ohio Division of the American Cancer Society, the committee offered advice and suggestions on matters of reorganization of the cancer organization; with respect to policies which will govern diagnostic clinics which may be established; and on the content of literature to be distributed to the public.

Suggestions and criticisms have been presented to the National Hospital Service Plans Commission (Blue Cross) regarding the wording of its proposed national contract, specifically, the committee requested that such contracts be worded in such a way that professional services would not be included. This was in line with the standing policy of the State Association opposing the inclusion of professional services in Blue Cross contracts.

RURAL HEALTH PROBLEMS

The question of improving rural health conditions has been considered by the committee. One conference with representatives of farm organizations was held. Representatives of the State Association have participated in several meetings called by the farm groups for frank discussions of the health and medical problems of rural areas. These matters will be given more thorough attention in the future through a special committee which has been appointed by President Schriver.

Active interest has been taken in the proposed survey of hospital and health facilities in Ohio under the supervision of the Ohio Commission on Hospital Care, named by Governor Lausche at the request of the Ohio Hospital Association. The State Association is represented on the survey commission and it has offered to make a

financial contribution to the commission, if necessary, in order that the study can be undertaken and completed at an early date.

CHEST SURVEYS

Following conferences with officials of the Ohio State Radiological Society, the committee drafted a statement of policy regarding mass chest surveys for public health purposes, which was approved officially by The Council. In brief, the policy approves the principles of such surveys, providing those conducting the surveys request and receive the approval of the local medical society; the films are examined by trained and competent physicians; cases needing further study and care are referred to local physicians, whenever feasible; and the question of fees is left for local determination.

The desirability of greater use of the radio by the State Association for the purpose of keeping the public informed of the views and policies of the medical profession on health matters has been considered. On recommendation of the committee, The Council has approved in principle a plan suggested by the Michigan State Medical Society for a radio hookup involving a dozen or more Midwestern state medical societies and has offered to make a financial contribution to such plan providing the specific arrangements are acceptable to The Council. The possibilities of having the Ohio State Medical Association engage time for regular radio broadcasts are being explored.

Frequent conferences have been held with Dr. Roger E. Heering, Ohio Director of Health, and Mr. Frazier Reams, Ohio Director of Public Welfare, and members of their staffs, on matters of mutual interest and the active assistance of the committee has been accorded to them.

PUBLIC RELATIONS

Many activities in the field of public relations, which, obviously, are not a matter of record, have been carried on by the members of the Columbus office staff under the direction of the committee. As recorded in the minutes of the meeting of The Council held in December, 1945, and published in the January, 1946, issue of *The Journal*, the Department of Public Relations of the State Association has been reactivated and reorganized with Mr. George H. Saville, the assistant executive secretary, in charge. The employment of Mr. Hart F. Page as assistant to the director will provide the Department with long-needed additional personnel.

Under this reorganization, the Department will now be able to carry on former activities which had to be abandoned because of the resignation of the former director and because of wartime conditions, and to expand its work to meet new demands, providing, of course, the House of Delegates acts favorably on the request to be submitted by The Council for an increase in the per capita annual dues of the State Association. In this connection, the committee desires to endorse the recommendation for an increase in the annual dues as it is convinced that the Association can not fulfill its responsibilities in the field of public relations under its present budget. A good public relations job—one which the membership wants and expects to be done—can be done if funds are provided for a well-organized department, for the production of material, and for securing the advice of outside public relations counsel when necessary.

Barney J. Hein, M. D., Toledo, Chairman,
Committee on Public Relations and Economics.

REPORT OF COMMITTEE ON MEDICAL SERVICE PLANS

The Committee on Medical Service Plans is pleased to be able to report to the membership that the objective which was set forth in a resolution adopted by the House of Delegates at the 1944 Annual Meeting has been achieved; namely: The organization of a voluntary prepaid medical care plan for Ohio.

Chapters could be written about the numerous meetings which were held by this committee and the multitude of details handled by the committee leading up to the formation of Ohio Medical Indemnity, Inc.

Inasmuch as all of the important activities of the committee have been reported through the minutes of meetings of The Council or in special articles in *The Journal*, the committee will confine this report to a few comments regarding the present status of Ohio Medical Indemnity, Inc., and its future possibilities.

As most of the members undoubtedly know, Ohio Medical Indemnity, Inc., is at present operating in a 14-county area in Southwestern Ohio, making use of many of the administrative and clerical facilities of Hospital Care Corporation, Cincinnati, the Blue Cross Hospital Service Plan covering that part of the state.

SUBSCRIBERS BEING ENROLLED

At the time this report was prepared, Ohio Medical Indemnity, Inc., had approximately 5,000 contracts in effect, covering approximately 12,500 individuals. An energetic enrollment campaign was under way and widespread interest and enthusiasm were being shown by employees and employers of the 14-county area. There is every reason to believe that Ohio Medical Indemnity, Inc., will enjoy a substantial growth during the ensuing months, meeting a demand and need for a sound plan whereby wage earners can indemnify themselves and their families for the costs of medical care.

Quite wisely, the officials of Ohio Medical In-

demnity, Inc., most of whom are officials or former officers of the Ohio State Medical Association, have decided to conduct the affairs of the organization on a conservative basis. They believe that Ohio Medical Indemnity, Inc., must learn to walk before it is ready to run. For that reason, no effort was made at the beginning to extend its activities into all parts of Ohio. At present, efforts are being concentrated in one section of the state, a section, however, with more than 500,000 subscribers to the Blue Cross plan, all of whom are potential applicants for Ohio Medical Indemnity, Inc., coverage.

WILL EXPAND AT PROPER TIME

After gaining experience in administrative details, underwriting policies, and the like, in Southwestern Ohio, the company will expand its activities to other parts of the state. Preliminary arrangements for working agreements with other Blue Cross plans in Ohio have been made, so the company will be able to begin the enrollment of subscribers in communities not covered at present just as soon as it is advisable and feasible for the company to do so.

Also, this same conservative policy was followed in the preparation of the indemnity contract which Ohio Medical Indemnity, Inc., is offering. No attempt has been made to provide indemnities for all procedures involved in the care of the sick and disabled. However, as soon as the company has accumulated underwriting, financial, and administrative experience, the officials plan to give consideration to the possibility and feasibility of adding to the schedule of indemnity benefits so that all subscribers will receive wider coverage.

Ohio Medical Indemnity, Inc., was fortunate in being able to secure the services of Mr. Charles H. Coghlan, formerly assistant director of Michigan Medical Service, as Executive Vice-President. Because of his experience in and knowledge of prepaid medical care programs, Mr. Coghlan has been able to provide Ohio Medical Indemnity, Inc., with sound and expert administrative guidance from the very beginning.

OPTIMISTIC ABOUT FUTURE

Your committee is convinced that Ohio Medical Indemnity, Inc., will become one of the outstanding voluntary prepaid medical care plans in the country. It is controlled by the medical profession which contributed the funds necessary to organize under the Ohio Insurance Laws. It is sound from administrative and organizational standpoints. Its coverage is liberal; its charges to subscribers are reasonable. It meets the principles recently established by the American Medical Association governing approved voluntary prepaid medical care plans, and there is every reasonable expectation that it will shortly have, with other plans, the official seal of approval of the Council on Medical Service and Public Relations of the A.M.A.

Also, there has just been formed the Associated Medical Care Plans, Inc., a nation-wide group of voluntary prepayment medical care plans. In this Ohio Medical Indemnity, Inc., will participate. Through this will be effected reciprocity among all qualified plans, thus providing the widest geographical protection possible for subscribers to all approved voluntary medical care plans.

NATIONAL PROGRESS REPORTED

Incidentally, the committee wishes to commend the Americal Medical Association for this new and progressive venture. From now on, local and state medical care plans sponsored by local and state medical societies which qualify under the standards established by the Council on Medical Service and Public Relations of the A.M.A. will be assured of the guidance and support of the American Medical Association. This will go far toward realization of the hope of medical organization—the establishment of a nation-wide program of voluntary prepayment medical care coverage through direct cooperation and sound working arrangements between the various qualified local and state plans.

During its many and lengthy deliberations preliminary to the formation of Ohio Medical Indemnity, Inc., this committee received great help and splendid cooperation from representatives of the Ohio Association of Hospital Service Plans, especially from Mr. James E. Stuart, executive director of Hospital Care Corporation, Cincinnati, and Mr. Ralph Jordan, executive director of Central Hospital Service, Columbus. The committee desires at this time to express to them its sincere appreciation for the assistance and advice which they gave to the committee.

SUPPORT OF MEMBERSHIP APPRECIATED

Your committee is proud of the interest and enthusiasm which has been displayed by so many members of the Ohio State Medical Association in this vital undertaking. We are confident that many, many more physicians would have participated financially in this project had an intensive campaign for funds been necessary. However, one letter to the membership produced more than enough money for the organization of the company, making followups or field work unnecessary.

The interest shown by physicians all over the state indicates that the profession is solidly behind the State Association in sponsoring this constructive program. It indicates that the doctors of Ohio are abreast of the times and that they are not only willing, but capable, of carrying on activities which will provide sound solu-

tions to the health and medical problems of the people of Ohio.

AN APPEAL FOR COOPERATION

The success of Ohio Medical Indemnity, Inc., will depend to a considerable degree on the future attitude and cooperation of the members of the medical profession. The program preserves the principle of physician-patient relationship. Its underlying philosophy is that medical and health services can be provided on a prepayment basis through private enterprise. If subjected to abuse and sharp practices, the program will be unable to achieve its ultimate objectives.

To the membership generally, your committee directs this admonition: Remember, Ohio Medical Indemnity, Inc., is your plan. It is the answer of the medical profession of Ohio to those who desire prepayment coverage for the costs of medical care and to those who argue that a governmental plan is the only method of meeting this demand. It warrants the wholehearted support of every physician—in fact, will need such support at all times.

Robert C. Rothenberg, M.D., Cincinnati,
Chairman, Committee on Medical Service Plans.

REPORT OF COMMITTEE ON EDUCATION

During the war, the activities of the Committee on Education were curtailed. However, the committee in the near future expects to take steps toward reviving the Postgraduate Lectures of the State Association which had been presented with considerable success in various areas of the state in the years preceding World War II. Efforts will be made to provide through these programs refresher and review work for returning medical officers and for physicians who, during the war, were unable to leave their practices for postgraduate work.

With the advent of V-E Day, the committee prepared to assist returning medical officers in obtaining refresher and postgraduate training. Conferences were held with representatives of the Ohio Hospital Association and representatives of Ohio's three medical schools for the purpose of stimulating an expansion of opportunities and facilities for postgraduate work.

Efforts are now being made by Ohio hospitals which are approved for residency training to enlarge their facilities and courses so as to accommodate as many returning veterans as possible. Ohio's medical schools have developed refresher and review courses. At present, the demand for training far exceeds the number of opportunities offered, but efforts are being made to overcome this shortage.

At the request of the committee, the Ohio Department of Education has placed all of Ohio's approved agencies for postgraduate medical training on the list of institutions accredited to offer training under the provisions of the G. I. Bill of Rights.

HELPFUL FOLDER DISTRIBUTED

In the Fall of 1945, the committee assembled a folder entitled, "Postgraduate Medical Education Opportunities for Veterans". This file contains data on approved residencies and fellowships in Ohio and throughout the nation; information on courses offered by Ohio's medical schools to returning medical officers; listings of postgraduate continuation courses offered by medical schools and hospitals throughout the country; and up-to-date information on the educational provisions of the G. I. Bill.

These folders have been distributed to several hundred returning medical officers and will be furnished on request by the Columbus office to any physician.

This service has been found extremely useful by many returning medical officers. Obviously, there can be no guarantee that a veteran will be able to obtain an appointment in any specific hospital or medical school; nevertheless, the file referred to presents leads which can be followed up by the veteran and provides him with authentic information on the work and standing of all approved institutions.

HEALTH EDUCATION ACTIVITIES

Several actions of more than routine importance have been taken by the Sub-Committee on Public Health Education of the Committee on Education.

A statement prepared by the sub-committee, and adopted by The Council, regarding the so-called rapid treatment methods for curing syphilis was sent to all Ohio newspapers and published by many of them. The statement expressed concern over the "colorful" articles which had been appearing in the lay press regarding the rapid treatment methods, charging that over-emphasis has left the impression with the public that syphilis is no longer to be regarded seriously and that such articles may tend to develop an attitude of promiscuity among formerly fearful individuals to such an extent that the number of cases of syphilis may increase rather than decrease. The statement in its entirely was published on page 1167 of the December, 1944, issue of *The Journal.*

As a result of its relationship with the Ohio Division of the American Cancer Society, the sub-committee developed two articles on the topic, "Cancer and the General Practitioner", which were published in the February and May, 1945, issues of *The Ohio State Medical Journal.* The purpose of these articles was to elicit greater

interest in the cancer problem and encourage the early diagnosis of malignant disease.

Direct contact has been maintained between the State Medical Association and the Ohio Division of the American Cancer Society due to the fact that the chairman of this committee has served as a member of the Executive Committee and Board of Directors of the cancer organization.

On several occasions the sub-committee has submitted advice and recommendations to the State Department of Education on matters pertaining to health educational activities, health examination of school children, etc. The chairman of the committee, together with other members of the State Association, has served on the health advisory committee to the Department. Representatives of the Association have participated in the "Schools Work Shop" sponsored by the Department for those teaching subjects on health.

In the future this committee hopes to be able to hold regular meetings for the purpose of expanding its contacts and developing material which can be presented to the public on behalf of the Ohio State Medical Association.

Carl A. Wilzbach, M.D., Cincinnati,
Chairman, Committee on Education and
Sub-Committee on Public Health Education.

REPORT OF COMMITTEE ON WAR PARTICIPATION

This is the "swan song" of the Committee on War Participation which the committee presents without regret as it is further tangible indication that the great war has ended and that normal conditions so far as the medical profession is concerned are rapidly approaching.

Established as an emergency agency, the Committee on War Participation coordinated its activities with those of the Procurement and Assignment Service. During the past 12 to 18 months, its activities have entailed for the most part efforts to maintain a proper balance between the demands of the armed forces and those of the civilian population for medical personnel.

Considerable effort was put forth by the committee to supply physicians for areas in need of physicians and to assist physicians in finding locations where their services would be of the most value.

Also, the committee worked with the Procurement and Assignment Service in assisting hospitals to maintain adequate intern and resident staffs and in securing the release of medical officers for essential civilian practice in acute areas.

By action of The Council in December, 1945, the Committee on War Participation was deactivated and a new committee, known as the Committee on Medical Care of Veterans, created.

In terminating its work, the Committee on War Participation desires to express its appreciation for the excellent cooperation it has received from local committees, local society officers, officers of the State Association, and the membership generally. The record made by the medical profession of Ohio on both the fighting and home fronts is one of which the profession can be proud.

Robert Conard, M.D., Wilmington,
Chairman, Committee on War Participation.

REPORT OF COMMITTEE ON MEDICAL CARE OF VETERANS

By special action of The Council, the Committee on Medical Care for Veterans was created to cooperate with the U.S. Veterans Administration in setting up in Ohio a program to provide veterans with service-connected disabilities good medical care, such care to be furnished in so far as feasible by physicians in private practice.

Specifically the duties and responsibilities of the committee are: (1) To serve as a liaison between the medical profession of Ohio and the Veterans Administration; (2) to serve as a liaison between the Ohio State Medical Association and its component county medical societies and individual members on medical health matters affecting veterans; (3) to cooperate with other organizations and to represent the State Medical Association in state-wide activities dealing with veterans' medical and health questions; (4) to serve in an advisory capacity to officials of the Veterans Administration on medical and health matters; (5) to cooperate with and assist the Veterans Administration whenever and wherever possible; (6) to draft general policies and procedures for consideration of The Council and for the guidance of county medical societies; (7) to assist county medical societies in setting up suitable local medical and health programs for veterans.

The committee had held two meetings in Columbus up to the time this report was prepared. The work of the committee to date has been reviewed in articles published in the January and March issues of *The Journal* and in the minutes of the March 10 meeting of The Council, published elsewhere in this issue of *The Journal.*

However, the following abstract of the important activities of the committee is presented for the information of the House of Delegates and membership at large:

1. Each county medical society has been requested to create a Committee on Medical Care of Veterans to cooperate with the state committee and to handle local details on matters relating to medical and health services for veterans under agreements with the Veterans Administra-

tion. Approximately 45 counties have organized such committees.

2. Each county society has been requested to furnish the state committee with the names of physicians willing to make physical examinations of veterans applying for disability compensation. Such examinations would be made where possible by physicians in the home towns of veterans. To date lists of physicians indicating a willingness to make such examinations have been received from 27 counties. These lists are being submitted to the Ohio offices of the Veterans Administration so that veterans may be advised of the names of physicians near their homes who will make physical examinations of those applying for disability compensation.

3. At the suggestion of the Veterans Administration officials, the committee has offered advice regarding the qualifications of consulting specialists in order that specialized services of a high quality will be available to veterans and to the Veterans Administration for special procedures.

4. A proposed agreement with the Veterans Administration for a state-wide program whereby disabled veterans would be able to receive medical care from physicians of their own choice was drafted by the committee, approved by The Council, and submitted to the Veterans Administration.

5. The committee through a sub-committee formulated a proposed schedule of fees as a part of the agreement referred to in Item 4. This has been approved by The Council and has been submitted to the Veterans Administration. It is patterned after the Ohio Workmen's Compensation fee schedule.

6. Representatives of the committee have held conferences with representatives of the Veterans Administration for the purpose of obtaining authentic information and to establish a sound working agreement on the many details involved in this big question.

7. The committee is planning to serve in an advisory capacity on a state-wide basis to the Veterans Administration and to set up district advisory and review committees to assist the Veterans Administration on all details.

On all occasions the committee has received the fullest cooperation and consideration from officials of the Veterans Administration. General Hawley, medical director, has been most helpful, giving to representatives of the committee who waited upon him in Washington valuable information and suggestions. A close working arrangement has been established with Mr. Ralph Stone, deputy administrator of Branch Office No. 9, Columbus, serving the states of Ohio, Michigan, and Kentucky, and Col. N. H. McNerney, medical director of the Branch Office. Both of these officials have solicited the cooperation of the Ohio State Medical Association and have aided the committee in its activities to date. Similar assistance has been accorded the committee from officials of the regional offices in Ohio.

At this time the committee is not in a position to give a more complete report of its work and its plans for the future. After the Ohio program has been in operation for a longer period, the committee will present an interim report to The Council. Efforts will be made to work closely with the Ohio officials of the Veterans Administration on matters of policy and detail in order that this important program can be carried on efficiently for the benefit of the veterans and to minimize paper work complications so far as physicians are concerned.

It is believed that a program such as the one proposed by this Association will provide veterans with good medical attention. It gives all physicians in private practice an opportunity to provide services. It permits the veteran free choice of physician. This is a real opportunity for the medical profession of Ohio to prove that a huge institutionalized program will not be necessary. Obviously, some veterans will have to be cared for in Veterans Administration hospitals. On the other hand, the medical needs of most of them can be supplied by physicians in private practice in the home communities of the veterans. It is the hope of the committee that all Ohio physicians will agree to participate when an official request is sent to them by the committee, asking them to express themselves on this matter.

As revisions in the program which has been recommended become necessary, suggestions will be made by the committee to the Veterans Administration. Should the committee find that there is a better method of handling this question, it will promptly present new recommendations to the Veterans Administration.

H. V. Paryzek, M.D., Cleveland, Chairman, Committee on Medical Care of Veterans.

REPORT OF SUB-COMMITTEE ON WORKMEN'S COMPENSATION

On April 16, 1944, the Sub-Committee on Workmen's Compensation of the Committee on Industrial Health held its initial meeting in Columbus. The committee was formed by authorization of The Council for the purpose of carrying on negotiations with the Ohio Industrial Commission with respect to changes in the Rules and Regulations Governing Medical Procedures in Workmen's Compensation Claims and revision of the Medical and Surgical Fee Schedule, a general revision of which had not been made since 1926.

Following many meetings in Columbus over a period of six months, the committee reported its

recommendations to The Council. These recommendations were approved by The Council and transmitted to the Commission. After study by the Commission and following several conferences with the committee, the Commission adopted a revised set of rules and a revised medical and surgical fee schedule, effective May 1, 1945.

MANY CHANGES APPROVED

Most of the recommendations offered by the committee were adopted by the Commission, providing many constructive changes in the rules and in the fee schedule. A comparison of the old and new fee schedules shows that increases were made in the fees for 62 procedures; fees established for 68 procedures which had not been listed in the old schedule; no changes made in 68 items; and decreases made in seven procedures.

Some of the suggestions made by the committee were not adopted by the Commission but the way was left open for further conferences on those matters. It is the hope of the committee that additional constructive changes will be made in the fee schedule as a result of future negotiations.

RESULTS OF COMMITTEE'S WORK

The net result of the work of the sub-committee is that substantial improvements have been made in the Workmen's Compensation Fee Schedule, giving Ohio a schedule comparable to that of any other state and one considerably better than that of most states. Although the sub-committee did not succeed in getting all of its recommendations approved by the Commission, it feels considerable progress was made. As a result, injured workmen will receive better medical care and physicians will be more adequately remunerated for services rendered.

This committee is deeply appreciative of the friendly and cooperative attitude shown by members of the Industrial Commission and its staff on this matter. Although realizing that the increases in the fee schedule would increase disbursements from the State Insurance Fund, the Commission took the position that many revisions upward were justifiable in the light of present-day conditions. Moreover, the Commission expressed itself as believing that the constructive recommendations offered by the Association would improve the entire medical setup of the Commission, thus insuring medical care of the highest type for claimants.

In conclusion, the sub-committee urges all members to give the Commission their fullest cooperation and to guard against abuses in their dealings with the Commission. At the same time, the committee desires to assure the membership that it expects to continue its negotiations with the Commission on procedures which still need correction and adjustment and stands ready to take up with the Commission matters of dispute or misunderstanding affecting any or all members of the Association.

Barney J. Hein, M.D., Toledo, Chairman,
Sub-Committee on Workmen's Compensation.

VOTE ON MAY 7 OR BEFORE

Unfortunately, the Primary Elections on May 7 occur during the Centennial Anniversary Meeting of the Ohio State Medical Association in Columbus. Therefore, physicians planning to attend the Annual Meeting, May 7, 8, and 9, should vote by absent voter's ballot or vote in the regular manner before leaving for Columbus.

Proposed Amendment to By-Laws To Be Voted on in May

The following resolution proposing amendments to the By-Laws of the Ohio State Medical Association will be presented by The Council to the House of Delegates for action at the 1946 Annual Meeting, May 7, 8, and 9, Columbus:

Be It Resolved, That the By-Laws of the Ohio State Medical Association be amended to read as follows:

In Chapter 4, Sec. 4, strike out the words "Committee on Annual Reports";

In Chapter 9, Sec. 7, strike out the words "Annual reports must be in the hands of the Executive Secretary at least sixty days prior to the annual meeting of the Association and shall be published in *The Journal* at least one month before the annual meeting of this Association", and in lieu thereof, substitute the following: 'Such committees shall submit reports from time to time to The Council for its consideration and for publication in *The Journal* in order that the membership may be informed of the work of such committees".

The purpose of the resolution is to eliminate the requirement for annual reports of committees and to require all committees to report frequently to The Council so that information on committee activities can be reported at intervals during the year in *The Journal.*

Columbus—Dr. Frank F. Tallman, State Commissioner of Mental Hygiene, spoke concerning the mental institutions of the State at the March 7 luncheon meeting of the Columbus Junior Chamber of Commerce.

Last Chance To Make Hotel Reservations for Annual Meeting, May 7, 8, and 9, in Columbus

NOW is the last chance to obtain preferred hotel accommodations for the Centennial Anniversary Meeting of the Ohio State Medical Association May 7, 8, and 9, in Columbus.

As the time of the meeting draws closer, it is proportionally more difficult for the hotels to furnish desirable rooms, conveniently close to State Meeting headquarters.

Look over the hotels listed below, select the one of your choice, complete the reservation blank at the bottom of the page and mail it **at once** to the hotel management. Your trip to Columbus will be a more enjoyable one if you know there are comfortable quarters awaiting you.

The meeting sessions will be located at the Neil House and Deshler-Wallick Hotel.

NAME AND LOCATION	No. of Rooms	Single	Double	Double Twin Beds	Suites
NEIL HOUSE 35 South High St.	665	$4.40-7.70	$5.00-9.00	$5.50-11.00	Rates on request
DESHLER-WALLICK Broad and High Sts.	1000	3.30-8.80	5.50-11.00	5.50-13.20	Rates on request
FORT HAYES 31 W. Spring St.	350	3.00 and up	4.50 and up	5.00 and up	7.00-20.00
CHITTENDEN High and Spring Sts.	275	2.00-3.00	3.00-4.00	3.50-6.00	
SENECA 361 E. Broad St.	250	2.50-4.00	4.00-5.00	5.00-6.00	8.00-12.00
SOUTHERN High and Main Sts.	250	2.50-3.00	3.50-4.00	4.00-4.50	
VIRGINIA Third and Gay Sts.	150	2.20 and up	3.30 and up	4.40 and up	
BROAD-LINCOLN 631 E. Broad St.	140	2.20 and up	3.30 and up	4.95 and up	3.85 and up

HOTEL RESERVATION BLANK

Mail this coupon to hotel selected

Manager _____ Hotel, Columbus, Ohio.

You are requested to reserve the following accommodations during the period of the Centennial Anniversary Meeting of the Ohio State Medical Association, May 7, 8 and 9, 1946, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double room with bath Price: _____

☐ Twin Bed Room with bath ☐ Suite

Arriving May _____ at _____ A. M. _____ P. M.

PLEASE VERIFY MY RESERVATION.

Name _____

Address _____

_____

VETERANS' INQUIRY DEPARTMENT

Ohio Openings and Locations Sought by Returning Medical Officers; Opportunities Available Listed

THE purpose of this department is to provide space without cost to Ohio veteran physicians for the publication of inquiries they may wish to make concerning an assistantship or residency, a partnership or space in an office, locations and purchase of a practice, purchase of equipment, etc.

The new feature also offers an opportunity for physicians who desire to dispose of their practice or institutions and agencies needing staff physicians to publicize this information for the benefit of service men.

The feature will appear monthly as long as there seems to be a need for it. The regulations governing it are: (1) The veteran submitting the inquiry must be an Ohio physician, i.e., one who was in practice in Ohio when he entered the service or was a native of Ohio but still in training when he entered in the service. (2) Inquiries should not exceed 35 words. (3) Copy must be submitted by the 20th day of the month preceding date of publication. (4) Unless otherwise specified, each inquiry will be carried in two consecutive issues of *The Journal* but no oftener. (5) *The Journal* reserves the right to reject or edit copy submitted; also, to eliminate the new department when and if conditions warrant. (6) Inquiries should be accompanied by full name, forwarding address and identifying data.

OPPORTUNITIES SOUGHT

PEDIATRICIAN: Navy medical officer, aged 33, graduate of Ohio State University College of Medicine, trained in pediatrics, interested in pediatrics practice—preferably with group clinic. V.I.D. No. 1, care of Ohio State Medical Journal.

GENERAL SURGERY: Discharged Army medical officer, age 35, graduate of Northwestern University Medical School, surgical residency in approved Ohio hospital, seeking general surgical practice in Ohio or associateship or assistantship with man in practice. V.I.D. No. 2, care of Ohio State Medical Journal.

OTOLARYNGOLOGY TRAINING: Training in Otolaryngology through residency or assistantship sought by Army medical officer to be separated from service soon; age 32; graduate of Ohio State University College of Medicine. V.I.D. No. 3, care of Ohio State Medical Journal.

OBSTETRICAL TRAINING: Discharged medical officer desires assistantship or short residency in obstetrics and gynecological surgery or general surgery for period of month, six weeks or two months; age 48; graduate of St. Louis University School of Medicine. V.I.D. No. 4, care of Ohio State Medical Journal.

SURGICAL ASSISTANTSHIP: Wanted by veteran, age 33; six years surgical training including year of thoracic surgery; four years of Army surgery in states and overseas. Available after January 2. Ohio license. V.I.D. No. 5, care of Ohio State Medical Journal.

SURGICAL PRACTICE: Discharged medical officer, age 32, graduate of Ohio State University College of Medicine and residency in surgery, University Hospitals, Minneapolis, desires surgical practice. V.I.D., No. 6, care of Ohio State Medical Journal.

EQUIPMENT NEEDED: Returning medical officer desires to purchase an Ear, Nose and Throat Unit, new, or second hand if in good condition. V.I.D., No. 7, care of Ohio State Medical Journal.

ARE YOU INTERESTED IN INDUSTRIAL MEDICAL SERVICE POSITION?

Physicians interested in industrial medical service may learn of opportunities in this field by applying to:

The Council on Industrial Health
American Medical Association
535 North Dearborn Street
Chicago 10, Illinois

In making application, physicians should supply the following data: Name, address, age, medical school, year graduated, licensure (date and state), special training, experience in general and industrial medicine.

PEDIATRICS OR GENERAL PRACTICE: Practice in pediatrics or general practice sought by discharged Army medical officer, 45 years of age, diplomate of American Board of Pediatrics. Willing to invest. Available immediately. V. I. D. No. 8, care of Ohio State Medical Journal.

LOCUM TENENS OR ASSISTANTSHIP: Wanted for eight months by discharged flight surgeon who will begin ENT postgraduate course Sept. 1; O.S.U. '37; aged 32; experienced in industrial surgical practice. V.I.D. No. 9, care of Ohio State Medical Journal.

SURGICAL RESIDENCY WANTED: By returning medical officer, age 46, with 15 years general practice and surgery; three years assistantship to general surgeon; 20 months in general surgery in Army overseas. Available after January 1. V.I.D. No. 10, care of Ohio State Medical Journal.

PRACTICE WANTED: Veteran will buy practice of retiring or deceased physician, small city preferred. Ten years' practice before entering service. V.I.D. No. 11, care of Ohio State Medical Journal.

INDUSTRIAL OR INSURANCE POSITION WANTED: By discharged Army medical officer. Ten years in general practice. Over three years in service, mostly spent as administrative head of installation doing large number of physical examinations. Age 44. V.I.D. No. 12, care of Ohio State Medical Journal.

OPHTHALMOLOGY TRAINING SOUGHT: Training in ophthalmology through residency or assistantship wanted by discharged Army medical officer; ten months' eye work in Army; capable refractionist. Age 34. Graduate of Ohio State University College of Medicine. V.I.D. No. 13, care of Ohio State Medical Journal.

TRAINING IN OTOLARYNGOLOGY: Discharged Naval flight surgeon, with 62 months of military service, age 41,

graduate of Ohio State University, desires post-graduate training in otolaryngology and refraction by means of residency or assistantship. V.I.D. No. 14, care of Ohio State Medical Journal.

ASSOCIATION SOUGHT: Discharged Navy medical officer, age 33, thorough training in internal medicine, especially cardiology, graduate of University of Cincinnati, desires association with established internist or group clinic. Will locate in small town in need of internist. Member of Cincinnati Academy of Medicine. V.I.D. No. 15, care of Ohio State Medical Journal.

INTERNIST SEEKS OPENING: Internist, with two and one-half years clinical training, completing American Board of Internal Medicine examinations, age 33, licensed in Ohio, desires association with group or well-established internist. Available after April 1, 1946. V.I.D. No. 16, care of Ohio State Medical Journal.

WANTS SURGICAL RESIDENCY: Veteran medical officer, age 36, with year's internship, year of general residency, two years of general practice and 57 months service in Army as battalion surgeon and 25 months with orthopedic section of general hospital, desires approved residency in general surgery. V.I.D. No. 17, care of Ohio State Medical Journal.

ASSOCIATE PRACTICE SOUGHT: Internist, age 31, graduate of University of Cincinnati College of Medicine, 1938, four years hospital training, including one year cardiac fellowship, eligible for certification by American board, desires association with internist or group. Available immediately. V.I.D. No. 18, care of Ohio State Medical Journal.

PRACTICE WANTED: Obstetrician and gynecologist. discharged medical officer, age 38, desires obstetrical and gynecological practice or association; eligible for American board. V.I.D. No. 19, care of Ohio State Medical Journal.

RESIDENCY DESIRED: A gynecological or surgical residency wanted by returning medical officer, age 42, with three and one-half years hospital training and 10 years general practice; available in March. V.I.D. No. 20, care of Ohio State Medical Journal.

ASSISTANTSHIP WANTED: Discharged Army medical officer desires assistantship with busy general practitioner. Graduate of Northwestern Medical School, 1940; one year rotating internship, Cincinnati General Hospital; special training and degrees in chemistry, physiology and gastroenterology; age 32; single. V.I.D. No. 21, care of Ohio State Medical Journal.

OPPORTUNITIES OFFERED

GENERAL PRACTICE: Opportunity for general practice in town of 1,000 in Northwestern Ohio. Only one other physician. Home and office space available. One of Ohio's best agricultural areas and good marketing section. Write W. L. G., care of Ohio State Medical Journal.

GENERAL PRACTICE AVAILABLE: Physician wishing to retire wants to dispose of practice to returning veteran. Located in Wilmington, Clinton County, excellent farming community; good roads. Equipment includes modern furniture, large supply of drugs, supplies and instruments and library. Office rent reasonable and equipment and practice priced to sell immediately. R. H. Vance, M.D., 114 East Locust Street, Wilmington.

INDUSTRIAL POSITION: Desirable position on medical staff of large rubber company; good salary. F.T.R., care of Ohio State Medical Journal.

INDUSTRIAL COMMISSION: Openings available in Medical Section, Ohio Industrial Commission. Consult Dr. Robert André, chief supervisor, Medical Section, State Office Bldg., Columbus.

PRACTICE AND OFFICE FOR SALE: Practice in community of 2,000, unopposed; modern six-room recently constructed brick office building for sale or rent. Combined industrial and rural practice. H.B.K., care of Ohio State Medical Journal.

PARTNERSHIP: Good location for young M.D. Will consider partnership, nothing to sell. Five-room apartment above office available for living quarters. Contact Dr. A. B. Martin, Blanchester, Ohio.

EMPLOYMENT OPPORTUNITIES: For physicians, good salary, institution for mentally deficient. Indiana license necessary. Write or wire Fort Wayne School, Fort Wayne 1, Indiana.

ASSISTANT DIVISION CHIEF: Position for physician as Assistant Chief, Division of Child Hygiene, Ohio Department of Health, available. Salary $4,400 to $4,800. Must be graduate of approved medical school, one year's internship and at least one year's graduate training, plus one year of training or experience in clinical pediatrics. Experience in maternal and child health desirable. Must be licensed in Ohio or eligible for licensure. Apply, Chief of Division of Child Hygiene, Ohio Department of Health, State Departments Building, Columbus 15.

STATE HOSPITAL STAFF OPENINGS: Staff physicians for various institutions serving the mentally ill, mentally defective and epileptic needed. Physicians who have had some psychiatric training or experience preferred but can offer positions to doctors who may be interested in becoming acquainted with the specialty. Two positions of special importance now open are: Superintendency, Youngstown Receiving Hospital (especially attractive for young physician with residency in psychiatry) and Clinical Directorship, Gallipolis State Institute (fine opportunity for man who has had neuropsychiatric training to become acquainted with those neurological conditions that cause epilepsy in addition to a chance to be a specialist in the field of true epilepsy). Consult Dr. Frank F. Tallman, Ohio Commissioner of Mental Hygiene, State Departments Building, Columbus 15.

PUBLIC HEALTH OFFICERS NEEDED: Several counties in Ohio in need of full-time health commissioners. Those with training and experience, or interested in public health work, may obtain complete details from Dr. Roger Heering, Ohio Director of Health, State Departments Building, Columbus 15.

AREAS NEEDING PHYSICIANS: A list of Ohio areas badly in need of physicians, primarily for general practice—communities which were not the residence of any medical officer prior to the war—will be furnished on inquiry by the Headquarters Office, Ohio State Medical Association, Columbus.

PRACTICE FOR SALE: Active practice in county seat, Northwestern Ohio, for sale. Average of 100 obstetrical cases a year. Most physicians in upper age group. Railroad and insurance appointments available. Introduction and help for limited time offered. Equipment includes X-ray, diathermy, modern furniture, complete tonsillectomy instruments, large supply of drugs and supplies. Complete records of patients on file. No real estate for sale. Nominal rent. Hospitals nearby. Thriving industries and fine agriculture community, with paved roads. Estimated price, without complete inventory, $4,000 to $5,000. Box X, Ohio State Medical Journal.

PRACTICE FOR SALE: Active practice in a community of 3,000, North Central Ohio. Large amount of industrial work in addition to regular practice. Equipment includes new X-ray, diathermy, modern furniture, drugs and supplies. No real estate for sale. Moderate rent. Estimated price $7,500, cash or terms. Will introduce for a short time. Write R.J.S., care of Ohio State Medical Journal.

TUBERCULOSIS HOSPITAL OPENING: Resident physician needed in this institution doing intensive collapse therapy, including surgery. Good opening for man who desires to enter this field of medicine. District Tuberculosis Hospital, Lima; H. H. Brueckner, M.D., superintendent.

VETERANS ADMINISTRATION: Openings for physicians as members of rating boards for either full time or part time duty. Basic salary $4300.00 per annum, with additional compensation for overtime. Contact nearest V.A. office for particulars.

PRACTICE AVAILABLE: General practice at Friendship, Scioto County; seven miles from Portsmouth, which has two hospitals; population of area about 8,000; centralized elementary school; within six miles of High School; two Protestant churches; combined residence and office, with four-acre plot, available for sale or rent; no other physician in community. G.F.J., care of Ohio State Medical Journal.

FULL-TIME RESIDENT PHYSICIAN NEEDED: At Homeplace, Perry County, Kentucky, operated by E. O. Robinson Mountain Fund as educational center for mountain people. Graduate nurse; clinic building being planned; affiliation with medical center in Cincinnati for consultation and specialized services; salary $5,000 per year, with home and transportation furnished. Write Dr. Howard P. Fischbach, 1122 Carew Tower, Cincinnati 2, Ohio.

PRACTICE AND HOME FOR SALE: Active practice established 10 years in town of 2000 with local post office serving 8000. Brick and stone home with modern interior. Has suite of rooms for office. All modern office equipment with stock of drugs and X-ray, diathermy, ultraviolet. Seeing more than 20 patients per day. Physician urgently needed. Forced by service-connected disability to retire from general practice. All is offered to a veteran for price of real estate alone. Liberal terms; can pay for all in three years from earnings. M. R. Wedemeyer, M.D., Oak Hill, Ohio.

Special Train to 'Frisco!

Tentative Schedule and Costs for Trip to A.M.A. Meeting; Those Interested Should Write Mr. Nelson Immediately

PRELIMINARY and tentative arrangements have been completed for an Ohio State Medical Association Special Train to the 1946 Annual Session of the American Medical Association at San Francisco, July 1-5, inclusive.

Members of the Ohio State Medical Association who are interested in joining the party and want to take members of their family on this attractive, all-expense, pleasure trip through the West, should communicate immediately with Mr. Charles S. Nelson, Executive Secretary, Ohio State Medical Association, 79 East State Street, Columbus, 15.

Applications will be filled in the order they are received. Get yours in immediately as it may be necessary to limit the number of persons in the party in accordance with facilities available.

Some details have not been worked out as yet but complete information will be sent to all interested as soon as more data is available.

WHAT TRIP WILL INCLUDE

As stated, the Special Train Trip will be an all-expense feature with certain exceptions.

The all-expense cost **WILL INCLUDE** round-trip railroad and Pullman fares from Chicago and back to Chicago; hotel charges at Los Angeles and Banff; costs of sightseeing at Denver Mountain Parks, Salt Lake City, Portland, Vancouver, Lake Louise and Banff; tips; transfer charges; and costs of meals en route to San Francisco and return to Chicago, with the exception of meals in Los Angeles.

The all-expense costs **DOES NOT** include railroad and Pullman fares from home city to Chicago and from Chicago to home city; costs of hotel, meals and sightseeing in San Francisco during the A.M.A. meeting; nor meals and sightseeing in Los Angeles.

Those planning to go to San Francisco on the Special Train, or independently, should write immediately for hotel reservations in San Francisco, addressing Dr. M. Lawrence Montgomery, chairman, Subcommittee on Hotels, 200 Civic Auditorium, San Francisco, Calif. In writing mention the fact that you are coming on the Ohio State Medical Special, if that is your plan. List of San Francisco Hotels is being published in issues of The Journal of the American Medical Association.

STARTING TIME; DATE OF RETURN

Under present plans, the Ohio State Medical Special will leave Chicago on June 25. It will arrive in San Francisco, July 1; It will leave San Francisco, July 5. It will return to Chicago on July 12.

ITINERARY OF THE SPECIAL TRAIN

TUESDAY, JUNE 25

Leave Chicago.

WEDNESDAY, JUNE 26

Arrive Denver.

Sightseeing trip through Denver Mountain Parks.

Leave Denver.

THURSDAY, JUNE 27

Arrive Salt Lake City.

Sightseeing trip of city, including Mormon Temple, etc.

Leave Salt Lake City.

FRIDAY, JUNE 28

Arrive Los Angeles.

Hotel accommodations will be provided for the stay of two and one-half days and two nights in Los Angeles. No sightseeing will be arranged as there are so many special sightseeing features offered by Los Angeles that a planned schedule would not be practical. The costs of meals and sightseeing in Los Angeles are not included in the all-expense rate.

SUNDAY, JUNE 30

Leave Los Angeles.

MONDAY, JULY 1

Arrive San Francisco.

The party will spend five days in San Francisco for the A.M.A. meeting and seeing the

wonders of the Golden Gate City. No expenses while in San Francisco are included in the all-expense rate. Hotel reservations must be made direct by all members of the party.

FRIDAY, JULY 5

Leave San Francisco.

SATURDAY, JULY 6

Arrive Portland.

Sightseeing trip along the gorgeous Columbia River with its falls, dams and scenic wonders.

Leave Portland.

SUNDAY, JULY 7

Arrive Vancouver, British Columbia.

Sightseeing trip of this typical Canadian metropolis.

Leave Vancouver.

MONDAY, JULY 8

En route on train through Canadian Rockies.
Arrive Banff.

TUESDAY, JULY 9

Sightseeing at Beautiful Lake Louise.

WEDNESDAY, JULY 10

All Day at Banff.

Since a wide variety of recreation such as golf, tennis, fishing, swimming, trail riding, hiking, etc., is available at this famous Canadian resort, no special schedule has been arranged for the day.

Leave Banff.

THURSDAY, JULY 11

En route through Canada.

FRIDAY, JULY 12

Arrive St. Paul.
Leave St. Paul.
Arrive Chicago.

Arrival in Chicago will be in time for members of the party to catch night trains out of Chicago for home cities.

The foregoing schedule has been tentatively arranged and will be carried out unless unforeseen circumstances necessitate modifications.

APPROXIMATE COSTS

Because a few details have not as yet been complete, it is impossible to quote exact figures on the all-expense feature costs at this time.

However, a close estimate indicates that the all-expense tour cost from Chicago and return to Chicago will be approximately $298.45 for one person in a lower berth.

This is the base cost. The cost of accommodations in rooms and compartments on the train will be proportionately higher. These rates can be quoted when types of accommodations desired are known.

The $298.45 quotation does not include railroad and Pullman fares from home city to Chicago and from Chicago to home city. It does not include meals and sightseeing in Los Angeles. It does not include expenses in San Francisco.

EQUIPMENT, MISCELLANEOUS INFORMATION

First-class, standard, air-conditioned railroad and Pullman equipment has been promised by the railroads.

First-class hotel accommodations will be provided in Los Angeles and at Banff.

A liberal allowance has been made for meals, so they will be of the best.

Excellent equipment for the sightseeing trips has been promised.

Detailed information, when available, will be publicized and will be sent to all persons who may be interested.

Those interested at this time in this attractive (and economical) trip should write immediately to Mr. Nelson.

The name or names of persons for whom space is to be reserved should be given. The ages of children should be given.

Buys White-Haines Co. Control

D. D. Hubbell has acquired a majority common stock interest in the White-Haines Optical Co., Columbus. Mr. Hubbell is president of the firm with which he has been associated since its organization in 1901. Recapitalization of the corporation will result in the issuance of 15-year 4% sinking fund debentures and shares of 4¾% cumulative preferred stock with par value of $100.

The company, which has branches in eight states, always has specialized in processing and selling products of the Bausch & Lomb Optical Co. and this policy will be continued.

International College of Surgeons

The International College of Surgeons, United States Chapter, will hold its 11th Annual Assembly and Convocation in Detroit, October 21-22-23, 1946. Surgical clinics in Detroit hospitals will feature the first morning of the Assembly. Thereafter all the meetings, the convocation, and exhibition will be held in the Masonic Temple. The Detroit Statler and the Book-Cadillac will be hotel headquarters. Copy of program and detailed information may be obtained by writing Dr. Louis J. Gariepy at 16401 Grand River Avenue, Detroit.

Reports to The Journal Show 282 Additional Ohio Doctors Released from Military Service; Total Reported, 1,358

THE names of 282 Ohio physicians recently released from military service have been reported to *The Journal* during the past month. This makes a total of 1,358 reported to *The Journal* as having been released from service since V-E Day.

The Journal has to compile lists which are being published from information sent to it by the returning medical officer, by members of his family or county society officers. It is hoped that such reports will be sent in promptly.

Returning medical officers are reminded that the Columbus office of the State Association is prepared to furnish information regarding areas needing physicians or postgraduate education data.

The following tabulation lists the names of Ohio medical officers who have been released and whose names were reported to *The Journal* during the past month. The city in which the physician practiced or resided prior to entering the service is shown in most instances. However, if he has changed locations and this information is known, the place of relocation is indicated. The rank shown is based on the latest information on file with the State Association, and may not be up to date in some instances. In the April issue it was reported that Lt. William Craver, Columbus, had been released from the Navy Medical Corps and that Capt. William M. Garrett, Frankfort, had been released from the Army Medical Corps. This information was erroneous. They are still on active duty.

Name	City	Rank
Abrahamson, Ira A.	Cincinnati	Col., A.U.S.
Allenbach, Theodore C.	Columbus	Lt. Col., A.U.S.
Alley, John R.	Greenville	Lt. Col., A.U.S.
Amato, Nicholas G.	Cincinnati	Capt., A.U.S.
Amstutz, Omar C.	Bellefontaine	Major, A.U.S.
Apple, James D.	Dayton	Capt., A.U.S.
Arn, Roy D.	Dayton	Lt. Col., A.U.S.
Aufderheide, Vincent A.	Dayton	Capt., A.U.S.
Ball, O. D.	New Lexington	Lt. Col., A.U.S.
Bane, Russell C.	Chillicothe	Major, A.U.S.
Bard, Alfred K.	Cleveland	Capt., A.U.S.
Barker, Taylor W.	Cincinnati	Lt. Comdr., U.S.N.R.
Baumes, Ogden H.	Cincinnati	Comdr., U.S.N.R.
Bean, William B.	Cincinnati	Lt. Col., A.U.S.
Beasley, William D.	Springfield	Lt. Col., A.U.S.
Bell, James R.	Cleveland	Lt. Col., A.U.S.
Benes, Franklin A.	Shaker Heights	Major, A.U.S.
Bennie, W. T.	Cleveland	Major, A.U.S.
Berman, Alvin L.	East Cleveland	1st Lt., A.U.S.
Bieser, Dietrich R.	Dayton	Capt., A.U.S.
Black, Sam H.	Louisville, Kentucky (formerly of Akron)	Comdr., U.S.N.R.
Blackstone, Paul A.	Bellville	Lt. Col., A.U.S.
Blondis, Robert R.	Cleveland	Capt., A.U.S.
Bowman, Robert E.	Cleveland	Lt. Col., A.U.S.
Boylan, Peter C.	Cleveland Heights	Lt. Col., A.U.S.
Braun, Emery J.	Akron	Capt., A.U.S.
Bremner, Elizabeth A.	Hartford, Conn. (formerly of Toledo)	Capt., A.U.S.
Breyfogle, Ernest E.	Orrville (formerly of Akron)	Capt., A.U.S.
Broglio, Antonio S.	Cleveland	Major, A.U.S.
Brown, Russell N.	Dayton	Capt., A.U.S.
Brown, Stanley E.	Cleveland	Major, A.U.S.
Brubaker, Wilbur K.	Elyria	Major, A.U.S.
Bryant, Richard D.	Cincinnati	Lt. Comdr., U.S.N.R.
Byrne, Thomas E.	Mentor	Lt. Comdr., U.S.N.R.
Caldwell, James S.	Cincinnati	Capt., A.U.S.
Campbell, Rundle D.	Mansfield	Capt., A.U.S.
Cannava, Andrew W.	Norwood	Capt., A.U.S.
Carson, J. H.	Martins Ferry	Col., A.U.S.
Catalano, Frank A.	Cleveland	Capt., A.U.S.
Chaney, Wilford E.	Shade (formerly of Dayton)	1st Lt., A.U.S.
Chapla, Albert B.	Lorain	Major, A.U.S.
Charvat, Thomas F.	Cleveland	Comdr., U.S.N.R.
Clark, Willard C.	Dayton	Lt. Comdr., U.S.N.R.
Clifford, Richard V.	Youngstown	Comdr., U.S.N.R.
Cohen, Sander	Cincinnati	Lt. Col., A.U.S.
Colombi, Christopher A.	Cleveland	Major, A.U.S.
Cowdery, K. H.	Huron	Capt., A.U.S.
Creamer, David M.	Bellaire	Major, A.U.S.
Davidow, Sidney	Youngstown	Major, A.U.S.
Del Vecchio, James J.	New York, N.Y. (formerly of Yorkville)	Lt. Col., A.U.S.
Dineen, Frederick J.	Painesville	Comdr., U.S.N.R.
Doernberg, Robert J.	Spencerville	Major, A.U.S.
Dorner, Arthur F.	Akron	Lt. Col., A.U.S.
Elliott, Philip H.	Zanesville	Comdr., U.S.N.R.
Elliott, William E.	Alliance	Major, A.U.S.
Emslie, Robert J.	Elyria	Major, A.U.S.
Engelman, Elmer D.	Columbus (formerly of Chillicothe)	Capt., A.U.S.
Epstein, Francis W.	Toledo	Major, A.U.S.
Errington, Allison F.	Akron	Comdr., U.S.N.R.
Faller, William W.	Cleveland	Capt., A.U.S.
Farmer, Howard	Piqua	Capt., A.U.S.
Fauster, John U., Jr.	Defiance	Lt. Col., A.U.S.
Feistkorn, Karl H.	Marion	Capt., A.U.S.
Feldman, Stanley L.	Cleveland	Capt., A.U.S.
Fisher, John A.	Cincinnati	Lt. Col., A.U.S.
Flax, Ellis	Cincinnati	Capt., A.U.S.
Foley, William T.	Cincinnati	Major, A.U.S.
Folger, Glen K.	Cleveland	Lt. Col., A.U.S.
Forman, Wiley L.	Columbus	Capt., A.U.S.
Forsythe, William E.	Cleveland	Major, A.U.S.
Frankle, H. P.	Cleveland	Capt., A.U.S.
Frederick, Lewis O.	Osborn	Capt., A.U.S.
Frick, David C.	Toledo	Major, A.U.S.
Friedmar, Sam	Toledo	Major, A.U.S.
Fusco, Patrick J.	Warren	Major, A.U.S.
Gall, Edward A.	Cincinnati	Lt. Col., A.U.S.
Gallagher, Clarence M.	Columbus	Major, A.U.S.
Gallagher, John F.	Steubenville	Lt., U.S.N.R.
Glomb, Albert M.	Cleveland	Comdr., U.S.N.R.
Goetz, John P.	Akron	Major, A.U.S.
Goldhamer, Morton L.	Cleveland	Major, A.U.S.
Goldstein, Harry	Cincinnati	Major, A.U.S.
Good, Roland H.	Van Wert	Major, A.U.S.
Goodman, Joseph I.	Cleveland	Major, A.U.S.
Goodman, Milton L.	Columbus	Capt., A.U.S.
Goodman, Sander	Cincinnati	Capt., A.U.S.
Gould, James A.	Dayton	Lt. Col., A.U.S.
Grothjan, Cletus A.	Toledo	Major, A.U.S.
Grove, Paul D.	Cincinnati	Major, A.U.S.
Halley, John	Vermilion	Capt., A.U.S.
Hamsher, John F.	St. Paris	Col., A.U.S.
Hankinson, D. O.	Columbus	Major, A.U.S.
Hanson, Kenneth B.	Cincinnati	Major, A.U.S.
Hardgrove, George L.	Doylestown	Lt. Col., A.U.S.
Harding, John R.	Cincinnati	Lt. Col., A.U.S.
Harris, William B.	Columbus	Capt., A.U.S.
Hatcher, Emerson R.	Columbus	Capt., A.U.S.
Hathhorn, Harold E.	Youngstown	Lt. Col., A.U.S.
Hawver, Kenneth G.	Lima	Capt., A.U.S.
Hayes, Thomas M.	Springfield	Capt., A.U.S.
Hebble, Joseph N.	Springfield	P.A.S., U.S.P.H.S.
Heery, Ralph	Norwood	Major, A.U.S.
Hendricks, John E.	Newark	Capt., A.U.S.
Hengen, Henry E.	St. Ann, Missouri (formerly of New Riegel)	Capt., A.U.S.
Herbert, Joseph M.	Washington C.H. (formerly of Youngstown)	Capt., A.U.S.
Hiestand, Richard C.	Springfield	Capt., A.U.S.
Hinnant, I. M.	Cleveland	Lt. Col., A.U.S.
Hirsheimer, Albert	Dayton	Lt. Col., A.U.S.
Horton, Robert J. M.	Boston, Mass. (formerly of Cleveland Hts.)	Capt., A.U.S.
Hudson, J. Robert	Madeira	Major, A.U.S.
Hughes, James J.	Columbus	Capt., A.U.S.
Hullinger, Clarence W.	Springfield	Lt. Col., A.U.S.
Hunter, Howard M.	Hamilton	Major, A.U.S.
Iglauer, Arnold	Cincinnati	Capt., A.U.S.
Irish, Everett A.	Akron	Major, A.U.S.
Jacka, Edwin R.	Ann Arbor, Mich. (formerly of Bryan)	Major, A.U.S.

Name	City	Rank
Jaffe, Hyman	Cleveland	Capt., A.U.S.
James, Frederick W.	Lancaster	Major, A.U.S.
Jansen, Joseph H., Jr.,	Cincinnati	Capt., A.U.S.
Johnson, James B., Jr.	Newark	Major, A.U.S.
Jones, Daniel V.	Cincinnati	Lt. Comdr., U.S.N.R.
Junkermann, E. B.	Columbus	Major, A.U.S.
Kackley, Desmond D.	Columbus	Major, A.U.S.
Kallenberg, Joseph B.	Cincinnati	Capt., A.U.S.
Kalmon, Morris	Akron	Major, A.U.S.
Kamesis, John J.	Cleveland	Capt., A.U.S.
Kaplan, Irwin	Cincinnati	Capt., A.U.S.
Kattus, Joseph H.	Cincinnati	Major, A.U.S.
Katz, Philip	Toledo	Capt., A.U.S.
Kaval, V. T.	Cleveland	Capt., A.U.S.
Kearney, John J.	Piqua	Lt., U.S.N.R.
Kendall, Milton M.	Youngstown	Capt., A.U.S.
Kesinger, Herbert F.	McArthur	Major, A.U.S.
Kessler, Morris M.	Cleveland	Lt. Col., A.U.S.
Kessler, Ralph J.	Cincinnati	Capt., A.U.S.
King, Boyd G.	Cleveland	Lt. Col., A.U.S.
King, Harry E.	Dayton	Capt., A.U.S.
King, Thomas A.	Columbiana (formerly of Cleveland)	Capt., A.U.S.
Knapp, John A.	London	Capt., A.U.S.
Knies, Phillip T.	Columbus	Lt. Col., A.U.S.
Koehler, Joseph S.	Dayton	Comdr., U.S.N.R.
Kuhn, H. N.	Bellevue	Lt. (jg), U.S.N.R.
Kunz, Franklyn C.	Akron	Capt., A.U.S.
Langacher, Karl T.	Mansfield	Capt., A.U.S.
Lapirow, Harry	Cincinnati	Major, A.U.S.
LaVallee, Joseph C. E.	Cincinnati	Comdr., U.S.N.R.
Leichliter, John W.	Cincinnati	Col., A.U.S.
Lemert, Charles C.	Cincinnati	Major, A.U.S.
Lepsky, Harry O.	Cincinnati	Capt., A.U.S.
Levin, Joseph J.	Canton	Major, A.U.S.
Liebschner, William R.	Sandusky	Major, A.U.S.
Lind, Samuel C.	Cleveland	Capt., A.U.S.
Lombardi, L. F.	Akron	Capt., A.U.S.
Longnaker, John W.	Norwood	Capt., A.U.S.
Lowenthal, Gerson	Cincinnati	Major, A.U.S.
Lowry, Forrest E.	Urbana	Lt. Col., A.U.S.
Luidens, Henry	Columbus	Lt. Col., A.U.S.
Lyle, Herbert P.	Cincinnati	Comdr., U.S.N.R.
Mack, Joseph A.	Canton	Major, A.U.S.
MacNiel, Alec C.	Shaker Heights	Major, A.U.S.
Marcus, David	Cleveland	Major, A.U.S.
Marks, Moses I.	Cleveland	Major, A.U.S.
Marsh, Carl D.	Memphis, Tennesse (formerly of Springfield)	Major, A.U.S.
Martin, George I.	Miamisburg	Lt. Col., A.U.S.
Martin, Marion R.	Geneva	Lt. Col., A.U.S.
Mattax, James O.	Warren	Capt., A.U.S.
Maurer, Elmer P. R.	Cincinnati	Major, A.U.S.
McCandless, Harvey G.	Cincinnati	Major, A.U.S.
McClure, Jasper R.	Cincinnati	Capt., A.U.S.
McConkey, H. H.	Canton	Major, A.U.S.
McCracken, John G.	Erieside	Sq. Leader, R.C.A.F.
McCready, Robert G.	Akron	Capt., A.U.S.
McDonald, Frank M.	Akron	Lt. Col., A.U.S.
McGuire, Johnson	Cincinnati	Lt. Col., A.U.S.
McGuire, Philip J.	Barberton	Major, A.U.S.
McLin, William M.	Dayton	Capt., A.U.S.
Mehl, Lawrence B.	Cuyahoga Falls	Major, A.U.S.
Melaragno, U. A.	Dayton	Capt., A.U.S.
Miller, John F.	Newark	Lt. Col., A.U.S.
Miller, Richard C.	Dayton	Capt., A.U.S.
Millikin, Neil	Hamilton	Major, A.U.S.
Minor, Howard H.	Steubenville	Major, A.U.S.
Moore, Charles H.	Cincinnati	Lt. Col., A.U.S.
Moorehead, James R.	Columbiana (formerly of Seville)	Major, A.U.S.
Morton, Joseph L.	Columbus (formerly of Cleveland)	Major, A.U.S.
Mowry, Ben F.	Findlay	Lt. Col., A.U.S.
Mumma, Charles E.	Dayton	Capt., A.U.S.
Muter, Clyde W.	Warren	Major, A.U.S.
Mutschmann, Paul N.	Warren	Lt. Col., A.U.S.
Newell, Leonard J.	Dayton	Comdr., U.S.N.R.
Nicholson, Owen J.	Norwalk	Major, A.U.S.
Noll, John, Jr.	Youngstown	Lt. Col., A.U.S.
Northrup, Deane H.	Marietta	Major, A.U.S.
Novy, Frank D.	Cleveland	Capt., A.U.S.
Nuckolls, Chester R.	Cleveland	Comdr., U.S.N.R.
Parke, G. K.	Akron	Major, A.U.S.
Parker, Watson D.	Sandusky	Lt., U.S.N.R.
Payne, L. Warren	Willoughby	Major, A.U.S.
Pease, Phillip P.	Chardon	Col., A.U.S.
Peirce, Wilmot W.	Mansfield	Capt., A.U.S.
Pfaadt, William E.	Coshocton (formerly of Cambridge)	Capt., A.U.S.
Pfarrer, Richard	Dayton	Lt., U.S.N.R.
Pfeiffer, Charles L.	Cincinnati	Lt. Comdr., U.S.N.R.
Piercy, Robert L.	Youngstown	Capt., A.U.S.
Pillersdorf, Louis	Cleveland	Lt. Col., A.U.S.
Press, Sanford	Steubenville	Capt., A.U.S.
Preston, William P.	Toledo	Capt., A.U.S.
Price, Pliny A.	Columbus	Capt., A.U.S.
Pugh, Luther S.	Perrysburg	Capt., A.U.S.
Pulford, Dayton T.	Toledo	Major, A.U.S.
Quinn, Gerald W.	Akron	Major, A.U.S.
Ralston, Joseph A.	Warren	Major, A.U.S.
Ramey, William O.	Cincinnati	Capt., U.S.N.R.
Read, John T.	Columbus	Major, A.U.S.
Reed, Howard W.,	Akron	Comdr., U.S.N.R.
Reese, Harold J.	Youngstown	Surg., U.S.P.H.S.
Renner, George, Jr.	Cincinnati	Col., A.U.S.
Robart, W. C.	Akron	Lt. Col., A.U.S.
Roberts, David J.	Akron	Major, A.U.S.
Robinson, Harold A.	Elyria	Major, A.U.S.
Rohr, Lovell W.	Columbus	Major, A.U.S.
Ross, Paul S.	Columbus	Major, A.U.S.
Russin, Lester A.	Cincinnati	Lt. Col., A.U.S.
Ryan, Nelson W.	Cincinnati	Major, A.U.S.
Sauvageot, John P.	Akron	Major, A.U.S.
Schiro, Harold S.	Cincinnati	Lt. Col., A.U.S.
Schirripa, F. R.	Cleveland	1st Lt., A.U.S.
Schneble, Richard C.	Dayton	Lt. Comdr., U.S.N.R.
Schonberg, Irving L.	Cleveland	Major, A.U.S.
Schumake, Lawrence P.	Cleveland	Major, A.U.S.
Scuderi, John J.	Akron	Capt., A.U.S.
Seidemann, Hans	Cleveland	Capt., A.U.S.
Sharp, William T.	Chillicothe	Major, A.U.S.
Shilling, M. D.	Ashland	Lt., U.S.N.R.
Sholl, John G., III	Cleveland	Capt., A.U.S.
Sidenberg, Stanley S.	Cleveland	Comdr., U.S.N.R.
Skinner, George C.	Cincinnati	Capt., A.U.S.
Sloan, Richard H.	Marietta	Capt., A.U.S.
Slomer, Norbert F.	Cincinnati	Major, A.U.S.
Smedal, E. A.	Mansfield	Major, A.U.S.
Smith, Corwin A.	Dayton	Lt. Col., A.U.S.
Smith, John W.	Grand Rapids	Capt., A.U.S.
Smith, Kenneth D.	Columbus	Major, A.U.S.
Smith, Richard N.	Wooster	Lt. (jg), U.S.N.R.
Speicher, Clyde M.	Cleveland	Comdr., U.S.N.R.
Sterne, Eugene H., Jr.	Cincinnati	Capt., A.U.S.
Sternlieb, Max	Ravenna (formerly of Wadsworth)	Capt., A.U.S.
Steuer, Leonard G.	Cleveland	Col., A.U.S.
Stevenson, Jean M.	Cincinnati	Lt. Col., A.U.S.
Stoodt, Paul A.	Mansfield	Lt. Col., A.U.S.
Strauss, Victor M. B.	Cincinnati	Major, A.U.S.
Strong, Joseph M.	Cleveland	1st Lt., A.U.S.
Suttle, Robert C.	Dallas, Texas (formerly of Put-In-Bay)	Capt., A.U.S.
Taliak, Martin B.	Cleveland	Major, A.U.S.
Tecklenberg, Roger L.	Lima	Major, A.U.S.
Thomas, Lester C.	Lima	Col., A.U.S.
Tichy, V. L.	Cleveland	Lt. Col., A.U.S.
Tildes, John H.	Lakewood	Lt. Comdr., U.S.N.R.
Tischler, George A.	Cleveland	Lt. Col., A.U.S.
Torrence, E. R.	Troy	Lt. Comdr., U.S.N.R.
Turner, Ray M.	Springfield	Capt., A.U.S.
Ulicny, Karl S.	Salem	Capt., A.U.S.
Vaughan, William T.	Akron	Capt., A.U.S.
Wagner, Carl F.	Cincinnati	Lt. Col., A.U.S.
Wagner, John L.	Barberton (formerly of New London)	Capt., A.U.S.
Walzer, Leo	Cleveland	Lt. Col., A.U.S.
Warm, Herbert	Hamilton	Lt. Comdr., U.S.N.R.
Warner, Calvin F.	Cincinnati	Capt., A.U.S.
Wartman, William B.	Cleveland	Lt. Col., A.U.S.
Weaver, Howard B.	Canton	Lt. Comdr., U.S.N.R.
Wetzel, Ralph E.	Cuyahoga Falls	Lt. Comdr., U.S.N.R.
Whitacre, H. E.	Bowling Green	Comdr, U.S.N.R.
Whitacre, James F.	Toledo	Capt., A.U.S.
White, Edgar H.	Cincinnati	Major, A.U.S.
Widzer, Ben	Cleveland	Capt., A.U.S.
Wilderom, Morris	Medina	Major, A.U.S.
Willis, W. H.	Painesville	Lt. Col., A.U.S.
Wilson, Sloan J.	Kansas City, Mo. (formerly of Columbus)	Lt. Col., A.U.S.
Wine, Charles R.	Dayton	Capt., A.U.S.
Wolf, Carl J.	Fremont	Major, A.U.S.
Yates, Ralph D.	Piqua	Comdr., U.S.N.R.
Zollinger, Richard W.	Columbus	Major, A.U.S.

Military News Notes

Lt. Col. Phillip T. Knies, Columbus, now on terminal leave, who was Army Quarantine Liaison Officer, Preventive Medicine Service, Office of the Surgeon General, has received the Legion of Merit for his work in the "planning, organization, and supervision of the Army foreign quarantine program".

"Assiduously active in the definition and solu-

tion of problems relating to foreign quarantine in military traffic", the citation stated, "Col. Knies was in a large measure responsible for protecting this Nation's people, agriculture, and various enterprises from foreign pestilences."

* * *

Brig. Gen. William C. Menninger, Director of the Neuropsychiatry Consultants Division, Office of the Surgeon General, has been awarded the Distinguished Service Medal for the primary responsibility for "solving one of the most serious medical problems facing the Army" in developing and putting into effect a treatment plan for neuropsychiatric cases. Gen. Menninger will be one of the guest speakers at the Centennial Anniversary Meeting of the Ohio State Medical Association at Columbus, May 7-9.

* * *

According to Maj. Gen. Norman T. Kirk, Surgeon General of the Army, there are 5,000 neuropsychiatric patients, 1,000 tropical disease patients, and 300 blinded soldiers still in Army hospitals. He also stated that there are 11,500 patients needing an estimated 31,000 operations in the nine centers specializing in hand and plastic surgery. In a recent talk at the annual dinner of the Society of Surgeons of New Jersey, Gen. Kirk pointed out that the most of the plastic surgeons, who have been working 12 to 14 hours daily, six days a week to carry this load, are eligible for separation on points, but it has been necessary to freeze them in the service.

* * *

Changes in station: Lt. Comdr., Lester Lasky, Zanesville, U. S. Naval Hosp., St. Albans, N. Y.; Lt. Comdr. J. C. E. LaVallee, Cincinnati, U. S. Naval Hosp., Portsmouth, Va.; Lt Col. J. E. McCarthy, Cincinnati, Oliver Gen. Hosp., Augusta, Ga.; Lt. Comdr. Thos. F. Ross, Columbus, U. S. Naval Hosp., Mare Island, Calif.; Lt. Alfred G. Allen, Cincinnati, Sta. Hosp., Boca Raton, Fla.; Maj. Jack A. Adelman, Columbus, 1345 AAF, BU, APO 433, c/o Postmaster, New York; Capt. Alfred M. Glazer, Cincinnati, Sta. Hosp., POE, New Orleans, La.; Capt. E. W. Arnold, Columbus, Mayo Gen. Hosp., Galesburg, Ill.; Maj. W. G. Hartnett, Fostoria, Sta. Hosp., Muskogee, Okla.

Lt. Wm. Craver, Columbus, Lake Forrest, Ill.; Maj. J. R. Raines, Cleveland, Fletcher Gen. Hosp., Cambridge; Maj. Frank E. Hamilton, Columbus, England Gen. Hosp., Atlantic City, N. J.; Capt. Homer R. Howell, Dayton, Sta. Hosp., Hamilton Field, Calif.; Capt. Albert Kostoff, Columbus, 1214 SCU, Redist. Sta., Atlantic City, N.J.; Lt. Col. Franklin A. Rice, Cleveland, Reg. Hosp., Ft. Knox, Ky.; Capt. Harold W. Ward, Columbus, Sep. Cen., Ft. Knox, Ky.; Capt. Geo. Y. Abe, Cincinnati, 1977 SCU Bushnell Gen Hosp., Brigham City, Utah; Lt. John C. Weeter, Cincinnati, Sep. Cent., Unit A, Camp Atterbury, Ind.; Capt. Joseph B. Kupec, Youngstown, Hdqrs. Sec., Wakeman Gen. Hosp., Camp Atterbury, Ind.; Lt. Howard F. Kuhn, Cincinnati, District Legal Office, USNTC, Great Lakes, Ill.

* * *

Comdr. John Toepfer, Cincinnati, is assistant naval attaché at the American Embassy, Chunking, China.

* * *

Recently separated from the service, Lt. Col. Paul E. Adolph, Bellevue, expects to return to his former work in China as a medical missionary some time in June.

* * *

The Legion of Merit has been awarded to Col. Warren C. Fargo, Cleveland, who has returned to the practice of pediatrics in Cleveland after nearly five years of active duty as Executive Officer, Assistant Commandant, and Commandant of the Medical Department Enlisted Technicians School, Brooke Hospital Center, Fort Sam Houston, Texas. The award was made for "performance of outstanding services from 15 Jan. 1941 to 15 Dec. 1945 in a position of great responsibility, and through perfecting training methods, attaining superior results in the training of Medical Department Technicians". Col. Fargo also received a personal letter of commendation from the Surgeon General of the U. S. Army.

* * *

Lt. Col. Oscar E. Nadeau, Chicago, was awarded the Legion of Merit by the War Department for his services as chief surgeon at Fletcher General Hospital, Cambridge, from May, 1943, to V-J Day. The citation was the result of the treatment of approximately 18,000 wounded during that period without a surgical death.

WIN PROMOTIONS

Name	City	Rank
Abe, George Y.	Cincinnati	Capt., A.U.S.
Burkhart, S. E.	Cleveland	Lt., U.S.N.R.
Fralick, Charles	Columbus	Lt., U.S.N.R.
King, Arthur G.	Cincinnati	Col., A.U.S.
Kuhn, Howard F.	Cincinnati	Lt., U.S.N.R.
Leary, William G.	Cincinnati	Lt., U.S.N.R.
Raines, James R.	Cleveland	Major, A.U.S.
Read, William A.	Cleveland	Lt. Col., A.U.S.
Rose, Donald L.	Dayton	Major, A.U.S.
Toepfer, John B.	Cincinnati	Comdr., U.S.N.R.

Announce Fellowship Exams

The next oral and written examinations for Fellowship in the American College of Chest Physicians will be held at San Francisco, June 29, 1946. Applicants for Fellowship in the College who plan on taking the examination should communicate with the Executive Secretary, American College of Chest Physicians, 500 North Dearborn St., Chicago 10, Illinois. The Twelfth Annual Meeting of the College is scheduled to be held at the Sir Francis Drake Hotel, San Francisco, June 29 to July 2, inclusive.

Ways of Improving Health Services in Rural Ohio Areas Discussed at Conference Held March 12-13

MORE State funds to carry on an expanded health program in Ohio were asked in a resolution voted in a conference sponsored by the Ohio Rural Health Committee, March 12 and 13 in Columbus.

The conference also favored the institution of a broader school health education program in all Ohio schools, and stated that the method of election of county boards of health should be studied by rural health committees to determine whether a more effective method of election should be devised.

If the study of state health conditions and desirable standards for health departments indicate a need for more than two counties to unite in order to have an effective health unit, the group asked that the present law be amended to make this possible.

HOSPITAL BILL ENDORSED

In the field of national legislation, the Hill-Burton hospital construction bill, and the Priest mental hygiene research bill were approved.

Speakers at the conference on March 12 included A. R. Mangus, professor of rural sociology, the Ohio State University, who discussed "The Health Situation in Ohio"; Dr. Joseph Mountin, medical director, U.S. Public Health Service, "What Constitutes Comprehensive Health Protection for All the People?"; Dr. Harry Wain, health commissioner of Miami County, "The Local Public Health Program of Tomorrow"; Dr. Roger Heering, director, Ohio State Department of Health, "How Adequately Do Present Public Health Services Meet the Needs of the People of Ohio?"; and Joseph Lohman, Ph.D., department of sociology, University of Chicago, "Proposed National Health Programs".

On Wednesday morning, March 13, the conference began with a discussion of mental hygiene plans and developments in Ohio, by D. R. Sharpe, Ph.D., interim chairman of the Ohio Mental Hygiene Association; Charles S. Nelson, executive secretary of the Ohio Medical Association, spoke on the subject, "Securing and Maintaining Well Qualified Medical Personnel in Rural Communities".

Dr. Fred Mott, chief medical officer, USDA, Washington, discussed "Prepayment Plans for Medical Care, Health Services and Facilities", and Louis Blair, director of University Hospital, the Ohio State University, told how to secure and maintain hospitals and health centers.

SECTION DISCUSSIONS HELD

The conference then divided into four sections to discuss the above topics and bring back resolutions for the consideration of the entire group in formulating its program of action.

The various resolutions were acted upon Wednesday afternoon, and the conference was closed with a general summary by Dr. Mott, entitled, "The Road to Better Health in Rural America".

Presiding at the several programs were George H. Lasher, DVM, and farmer, Rutland; Joseph Fichter, Master, the Ohio State Grange; H. C. Ramsower, Ph.D., director of Ohio Agricultural Extension Service; and Harry Culbreth, the Ohio Farm Bureau Federation.

Others from the Ohio State Medical Association who participated in the conference were Dr. Carll S. Mundy, Toledo, chairman of the Committee on Rural Health of the Ohio State Medical Association; George H. Saville, assistant executive secretary; and Hart F. Page, news editor of *The Journal.*

COMING MEETINGS

Ohio State Medical Association, Columbus, May 7-9.

American Medical Association, San Francisco, July 1-5.

Aero Medical Association, Chicago, April 7-9.

American Association for Thoracic Surgery, Detroit, May 29-31.

American Association of Anatomists, Cleveland, April 4-6.

American Association for the Study of Goiter, Chicago, June 20-22.

American College of Physicians, Philadelphia, May 13-17.

American Dietetic Association, Cincinnati, Oct. 14-18.

American Pediatric Society, Skytop, Pa., May 1-3.

American Roentgen Ray Society, Cincinnati, Sept. 17-20.

American Society for Research in Psychosomatic Problems, New York, May 11-12.

American Surgical Association, Hot Springs, Va., April 2-4.

Annual Postgraduate Assembly, Mahoning County Medical Society, Youngstown, April 17.

Central States Dermatological Society, Detroit, April 27.

Interstate Postgraduate Medical Association, Cleveland, Oct. 15-18.

Northern Tri-State Medical Association, South Bend, Indiana, April 9.



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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

"SOCIAL PROGRESS, THE SUCCESS OF GREAT ENTERPRISES IMPLY COMBINATION OF LABOR"

With the Centennial Anniversary Meeting of the Ohio State Medical Association only a little more than a month away, we had occasion to refer to some of the early meetings of the Association for the purpose of securing certain historical data.

Of special interest was the address of Dr. E. B. Stevens, Cincinnati, "A Historical Review of Medical Associations in Ohio", delivered at the Twenty-Fifth Anniversary Meeting held in Cleveland, June 14-16, 1870. The text of Dr. Stevens' address was published in the official Transactions of the Ohio State Medical Society for 1870.

Part of his remarks manifested the underlying spirit of medical organization and revealed in classical language the real purposes and motives of what is now the Ohio State Medical Association. We quote:

> **"All excellence is the result of individual effort. But social progress, and the success of great enterprises, imply combination of labor. These two then go together—individual exertion and organized effort. The silent ant carries to its home its daily earnings—but after all it is a poor silent ant—though ever so busy. The winter's store is the aggregate of successful accumulations of the colony.**
>
> **"All important social results are typed in this general proposition.**
>
> **"Much that we do as individuals is only selfish—but wiser and better councils and purposes, aggregate the selfish labors of the individual, and develop the features of general advancement.**
>
> **"Those who love the profession of medicine have steadily and steadfastly worked upon this idea. The profession of medicine in its purity—and the profession of medicine in its greatness—is the result of this sort of aggregation of personal effort, and combined or organized plan."**

Let those who wonder why an Ohio State Medical Association, pause and ponder.

The words of Dr. Stevens furnish them with the answer. Moreover, his words offer a challenge to the Ohio physicians of the future—those who will carry the torch—those who will be charged with the responsibility of maintaining and sustaining the Ohio State Medical Association during the ensuing years in order that a "combination of labor" may become a reality throughout the second century of its existence.

"THE RESPONSIBILITY OF THE HONOR"

Among literature which crossed our desk recently was a transcript of the baccalaureate sermon delivered on June 14, 1945, by the Most Reverend Michael J. Ready, D.D., Bishop of Columbus, at the commencement of the Schools of Medicine and Dentistry, St. Louis University.

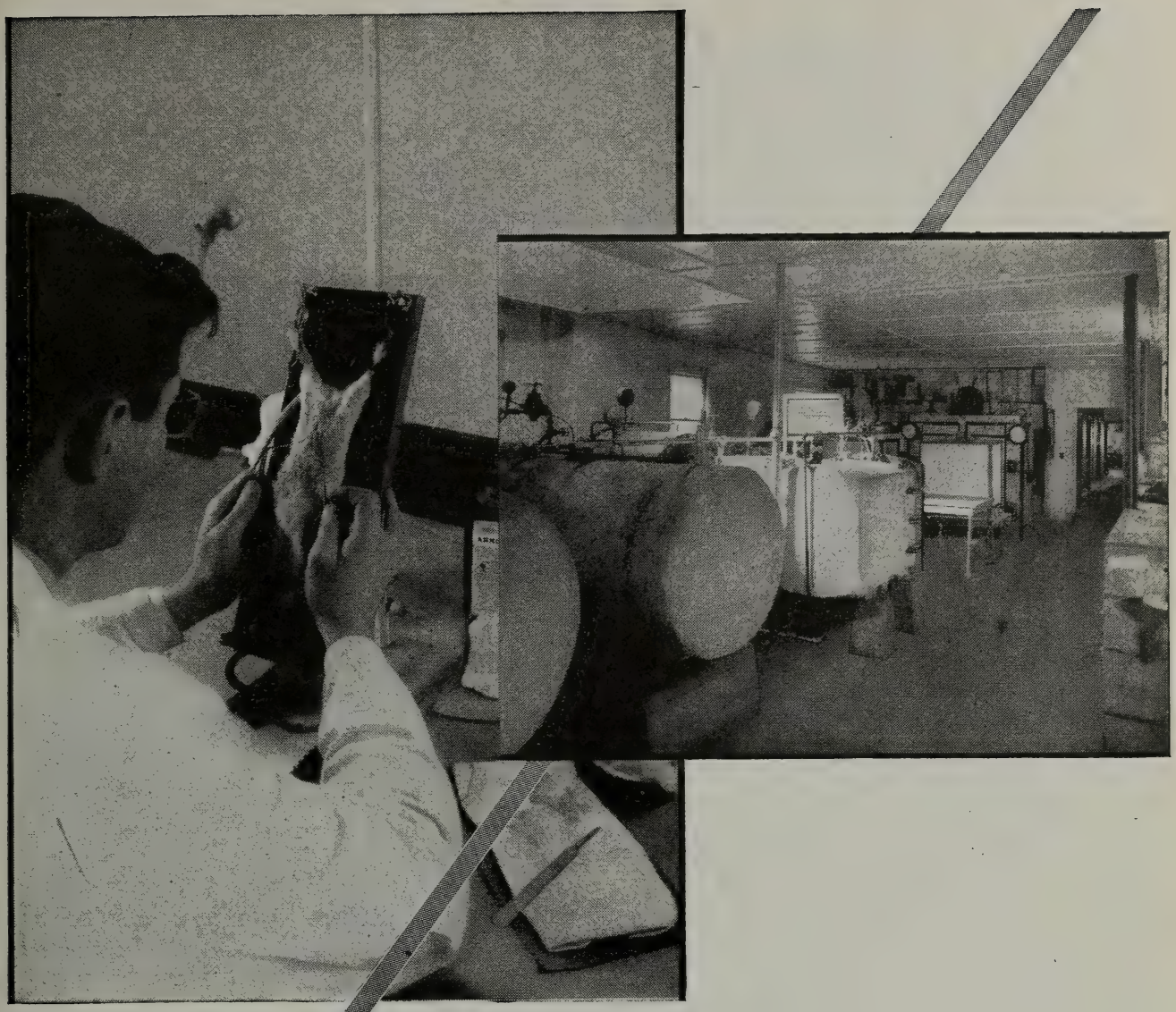
Every medical school graduate—every physician, in fact—should be required to read Bishop Ready's address, "The Honor of the Physician". A few excerpts will reveal why, in our opinion, this particular address is one of the most challenging messages ever directed to the medical profession.

Referring to the responsibility which accompanies the honor of being a member of the medical profession, Bishop Ready said:

"You are citizens of a favored country. This joy and dignity we all share with you. But, if I may borrow an expression from the writers of advertisements, I must call you 'super citizens.' Or you may paraphrase St. Paul; as each of you looks about him at his fellows in other walks of life, he may say, 'They are Americans; I am more!' Yes, your position in your country is one of inevitable prominence. If we are all equally citizens, you are among the first of equals. Soldiers in the line of advance are all equal; but some move first; some lead the way and set the pace. Upon their bravery and endurance depends, in great measure, the spirit and energy of those who follow. You take upon you now, with your professional character, a new civic and social responsibility. Henceforth your conduct, your opinions, your attitudes, will leave not only a stamp, but will exercise an active moulding force upon the American Body politic. You stand, regardless of your wishes in the matter, in the vanguard of national life and progress. America justly expects of you the type of citizenship that is literally exemplary.

"Your country would suffer a slackening of the bonds that hold her civic life at seemly level were you to prove careless or recreant in your slightest civic obligations. Physicians are not expected to be politicians. Neither are they to play the dilettante, the parlor radical, the loose tongued critic of men and matters. For 'what the doctor says' is taken as seriously among Americans as 'what the doctor ordered.' His work, because of his professional and social position, is held weighty and worth quoting in any department of thought or action.

"However, it is high time for the medical profession to speak more clearly to the American



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public on the variety of proposals and plans affecting doctor-patient relationships which citizens now regard as a heritage of freedom. A well organized propaganda actually has convinced many citizens that the medical profession stands in the way of better health services and facilities in our nation.

"Physicians generally have been in the front ranks of those best serving the community. Their very considerable personal sacrifices in serving the economically depressed citizens are not forgotten by thoughtful leaders in social welfare. The Profession's recommendations for constantly better standards of medical education, of hospital administration, and of more extensive public health programs are chiefly responsible for the magnificent progress in national health noted throughout our country.

"Government controlled and administered medical services have nowhere equalled the record achieved by this nation's traditional system of private medicine. Medical men should not permit a species of totalitarian propaganda to push them into a position of alleged opposition to better and to more widely attainable medical services for the people. The physicians and surgeons want what all decent citizens want. They want the public to have the best service and the best hospitals at the fairest cost to all.

"State control and an ever increasing taxation have never demonstrated in welfare and institutional management any special efficiency in better serving the public dependent on Government aid.

"Our citizens should exercise eternal vigilance in appraising plans and programs which hinder the individual from his right to select his own physician and which order a physician to engage his talents and skills according to bureaucratic control. It is well to remember in these days of sacrifice and death and struggle for liberty that so-called government benevolence can hide in edicts and decrees an even greater multitude of sins than charity can possibly cover.

"The watchword of a possible American totalitarianism will not be 'Heil der Fuehrer' nor 'Proletariat Unite' but some version of 'The State, like mamma, knows best—take it and like it!'

"Because of the physician's high civic responsibility, he will be conscious of a deep moral responsibility. For surely there can be no doubt or question about the root relation between morality and citizenship. The physician whose views on moral issues are loose, materialistic, agnostic, carelessly tossed off, fails as truly in civic as in moral duty."

WHAT PRICE SECURITY?

In his book, "Social Security—Past, Present, and Future", Gerhard Hirschfield estimates that a comprehensive system of compulsory social security in the United States would require each gainfully employed person to work 10 weeks at 40 hours, or 400 hours out of an annual total of 1,500 hours, or more than 25 per cent, just to pay for social security.

Who can be secure when government dips into pocketbooks to this extent for just one activity of government, exclusive of the "touch" in other varieties of taxes which a growing bureaucracy demands?

PLEA FOR AUTO PRIORITY FOR RETURNING PHYSICIANS

Recently during a conversation with the Secretary of the Ohio Automobile Dealers Association, we happened to remark that many of the returning medical officers are finding difficulty in obtaining an automobile which, of course, slows them up in resuming practice.

Guess he really took us seriously, for in a bulletin to his members under the heading "A Word for the Returning Doctors", he wrote his members as follows:

"Automobile dealers, in several places in the country, are giving all preference possible in the purchase of new automobiles to doctors, who are returning from the armed forces. In Ohio we know of many dealers who are giving all preference to returning veterans and this is fine!

"Doctors returning from the Service need automobiles to properly and quickly take care of the long line of patients that swamp every doctor's office and it would appear to your Executive Secretary that Ohio's dealers would be doing a real service in seeing that Ohio's doctors, returning from the Service, get the transportation needed to carry on their profession which is now under-manned. These doctors are the best customers automobile dealers have in normal times and here is a chance to show our appreciation".

Thanks for the lift, Brother Hamer. The docs appreciate your kind remarks and your sincere interest and help.

EDUCATION OUR BEST WEAPON AGAINST CANCER

During April, the Ohio Branch of the American Cancer Society, better known as the Ohio Field Army, will again ask the people of Ohio to make financial contributions for cancer educational activities in Ohio.

This project warrants not only the support of the public at large but of all physicians, individually and collectively. At present, education is the most potent weapon against cancer and through good education, many deaths from cancer can be prevented.

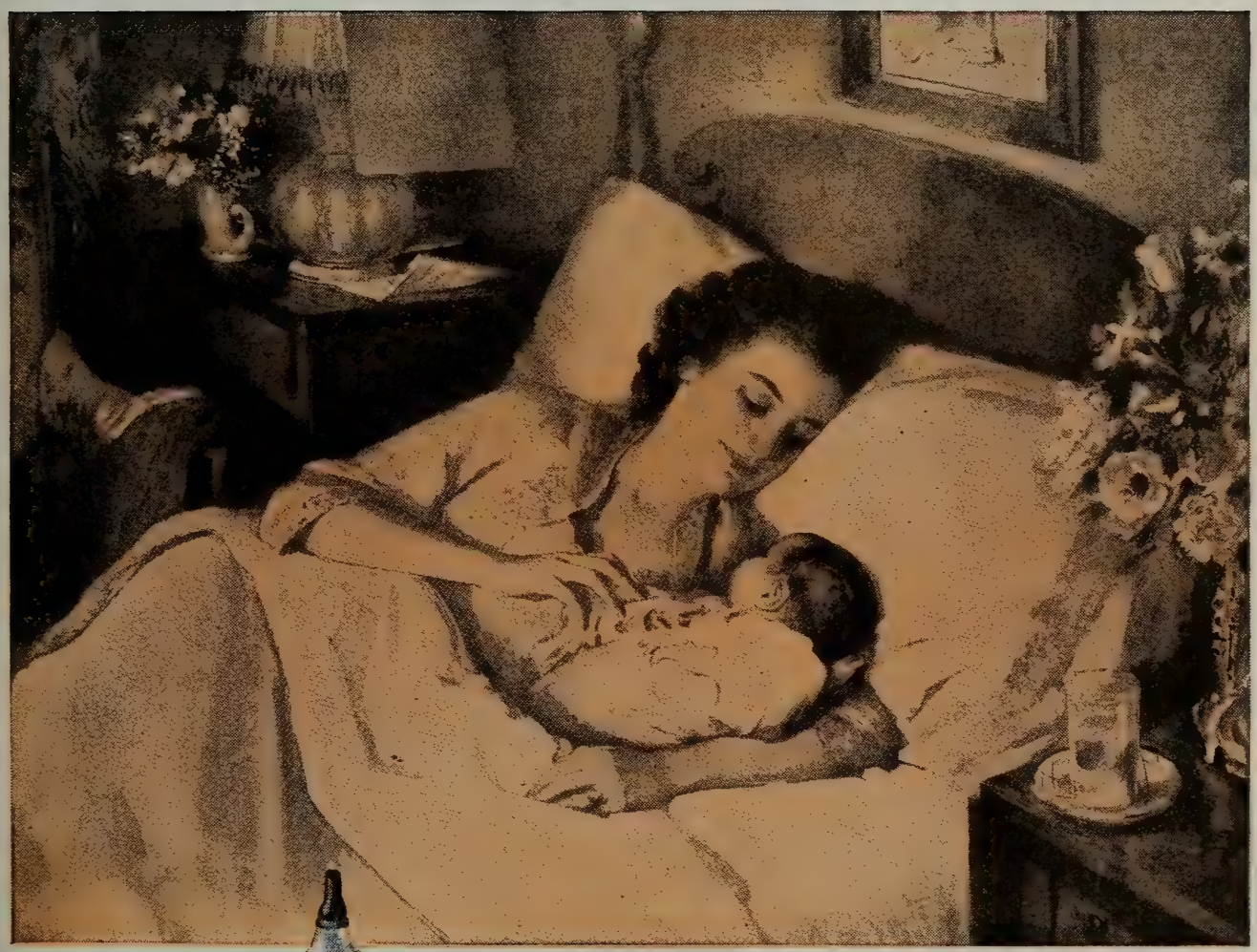
Dr. Morris Fishbein, writing in *Hygeia*, made these pertinent observations on the fight against cancer:

"Regardless, however, of the facilities and the medical advice that are available, these can do little to reduce the total number of unnecessary deaths unless people learn to overcome their fears and to seek the aid of these facilities at the earliest possible moment. In Sweden under a government system there are available to the people free diagnostic services and free transportation to government clinics with easy access to surgery and radium. Nevertheless, these facilities do not seem to have reduced materially either the deaths from cancer or the death rates. In a personal inquiry made to the physician in charge of one of the great cancer centers—the Radium Hemmet in Stockholm—he said that the public still fears cancer so greatly as to postpone the visit to the general practitioner in

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rural areas, who is in the vast majority of cases the first physician consulted.

"In the United States cancer of the breast caused 16,140 deaths in 1943; cancer of the uterus caused 16,968 deaths; cancer of the larynx caused 1,490 deaths; cancer of the tongue, 1,231 deaths; and cancer of the lips, 661 deaths. With the knowledge now available many of these deaths could have been prevented. These forms of cancer are in the majority of instances curable in their early stages. The figures cited indicate great possibilities if educational and medical facilities can be utilized to the utmost in getting the patient to the doctor as soon as possible and making available to the doctor modern methods for diagnosis and treatment."

The average doctor can play a mighty important role in this battle, seeking to instill in all his patients the necessity for periodic physical checkups and helping them to overcome their fears of cancer so they will not hesitate to report to him, or some other physician, when malignant disease is suspected.

BUREAUCRATS FORM LOBBY FOR HEALTH INSURANCE SCHEME

You may not know it (most taxpayers don't) but your hard-earned cash which you pay in taxes to Uncle Sam is being used (in no small amounts, either) to finance lobbying activities on behalf of the Wagner Compulsory Sickness Insurance Bill, S. 1606, the Pepper Bill, S. 1318, and sundry other proposals of a pink hue.

From the desk of Secretary of Commerce Wallace comes a mimeo, boosting the Wagner Bill, in which is found the peculiar declaration that "adoption of a nation-wide health program would be a tremendous aid to business, and the small businessman in particular".

From the Children's Bureau have come several releases urging adoption of not only the Truman health scheme but also the Pepper Bill which would provide medical care for all mothers and all "children" (anyone under 21) at government expense, regardless of need.

If you've attended any meeting recently when health has been the topic of discussion, you no doubt have discovered representatives of the U.S. Public Health Service on the program or participating in the discussions. Sure, they attended at the taxpayers' expense. And, they haven't failed to get in some licks for the Truman scheme, the Wagner Bills or what-have-you.

Of course, the boys at Washington will tell you they are engaged in "educational" activities—not lobbying. You draw your own conclusions.

It's going to be tough to take on Uncle Sam's brass button brigade but it's going to have to be done. Better get in and start pitching. There are plenty of groups and organizations in your community which need "educating".

PROPRIETY OF TRUMAN'S SPEECH QUESTIONED

Many Ohioans, including not a few members of the medical profession, have expressed regret that President Truman saw fit to inject invectives and log-rolling into his recent address in Columbus before the Federal Council of Churches of Christ.

Obviously, the President had a right to do what he did and say what he pleased but there is some question as to the propriety of using a churchmen's assembly for lobbying for his domestic program, including his compulsory sickness insurance scheme.

Many will agree with the *Cincinnati Enquirer* which commented on the Columbus speech in part as follows:

"Referring again to that part of the speech which addressed itself to national affairs, it seemed to us that the President skirted bad taste in advocating, by indirection, a religious fervor in support of his domestic program. The implication is that his legislative undertakings are religiously right. Some of them, of course, can be championed on a basis of moral or humanitarian need, but others have no claim whatever to holy purpose or effect, and are nothing but unneeded or half-baked legislative undertakings. The tragedy is that Mr. Truman himself has contributed to the legislative obstruction in Washington by demanding more of Congress than is wise or necessary."

A.M.A. VOLUNTARY PLAN BOOSTED BY P.D.

Writing under the title, "Voluntary Group Medicine", an editorial writer for the *Cleveland Plain Dealer* caught the spirit and intent of the recently-announced national health program of the American Medical Association.

Because it states the case of the A.M.A. so well and because it refutes so tersely the contention that a compulsory system of medical care is the only answer, we are taking the liberty of quoting the editorial in its entirety, as follows:

"Recognizing an obligation to play more than the role of critic of President Truman's compulsory health insurance proposal, the American Medical Association has come forth with a nation-wide, voluntary medical care plan of its own.

"The A.M.A. plan involves the formation of local associations, similar to the successful and popular group hospitalization associations, whose subscribers, by payment of regular and moderate fees or dues, will be eligible for necessary medical care from doctors of their choice, providing those doctors are participants in the plan.

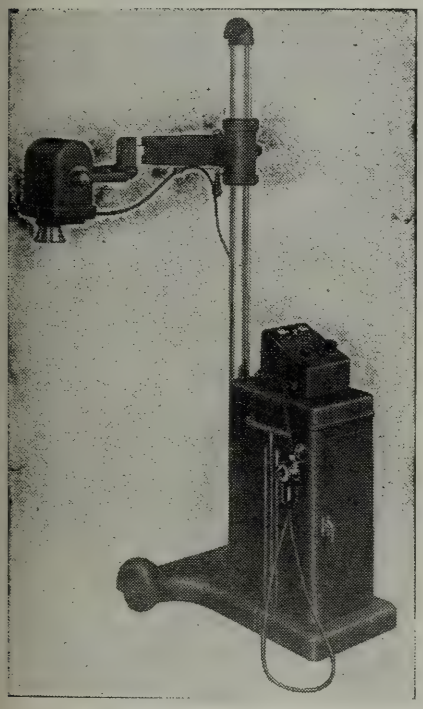
"The A.M.A. does not propose to organize these associations itself, but will allow the display of its seal of acceptance by any medical care plan which meets standards set by the A.M.A. and which has received the approval of the state or county medical society in the area in which it operates.

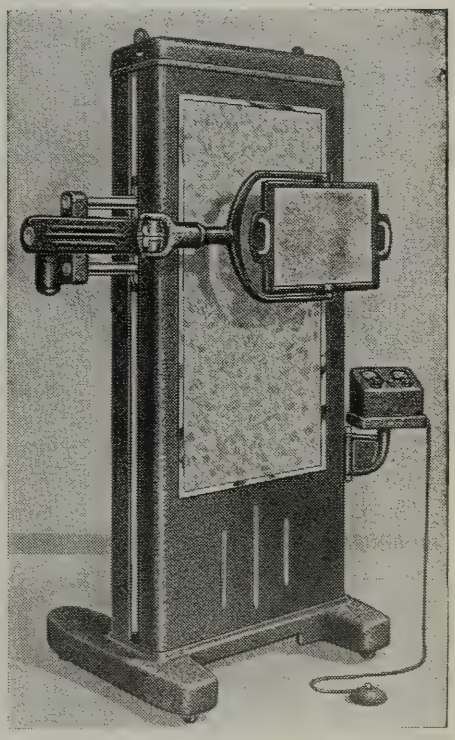
"The A.M.A. has, however, organized a voluntary federation known as Associated Medical Care Plans, Inc., which will act as a standard

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setting and co-ordinating body, making reciprocity possible between the local organizations, so that subscribers can be transferred from one plan to another or make use of the benefits in any state in which they happen to be located when in need of care.

"The growth of the hospitalization plans in the last decade or so has been such as to promise ready public acceptance of a similar plan for medical service, and it is safe to predict that within a comparatively few years the movement will become nation wide in fact. Inasmuch as this plan avoids the compulsory feature of Mr. Truman's proposal, it is much to be preferred.

"If this plan is successful, as there is every reason to believe it will be, it not only should head off movements for socialized medicine but also should have a tremendously beneficial effect on the health of the American people".

Off to a good start, it is now up to the A.M.A. to produce by following through and making the national program click.

Also, it is up to the medical profession to see that Ohio Medical Indemnity, Inc., the "doctors' plan" in Ohio, succeeds as it will play an important role as a link in the national program.

AND THEY CALLED IT A "WHITE PAPER"!

If an Associated Press dispatch from London, dated March 21, is an accurate job of reporting, the British Parliament is going to have a chance to vote on a broad national, government-financed medical and dental care program—and we mean broad.

According to the A.P. the proposal, drafted by Health Minister Bevan of the Labor Government, provides for:

PUBLIC OWNERSHIP of hospitals and free hospitalization for all patients who need it.

ESTABLISHMENT of new public health centers for hospital, clinical, dental and specialist services, with free treatment and medicine.

EYE EXAMINATIONS and the provision of glasses at no cost.

GRADUAL DISTRIBUTION of doctors by paying higher rates of compensation in doctor-scarce industrial and rural districts and by declining permission to new doctors to establish themselves in wealthy doctor-saturated districts.

Quoting from the dispatch:

"One of the terms which is expected to arouse fierce opposition from the medical association is a proposed ban on the long-established custom of doctors buying and selling practices.

"The bill proposes an appropriation of $264,000,000 to buy up the practices—an average of about $6,000.

"Doctors who work in public health centers would be paid a salary plus a small fee for each patient. Others could practice part time in the centers and carry on a private practice for people who elect to stay outside the public health plan."

The annual cost of the program was estimated at $608,000,000. It would cover 40,000,000 persons of England and Wales.

Kinda looks as if John Bull is trying to outtrump Uncle Joe.

And they had the nerve to call it a "white paper"!

Hold your hat, pal! The distance across the Atlantic ain't what she uster be. They've got "white paper" in Washington, too—pink, also, we've been told.

Jolly time, old chappies! Drop us a line sometime when you can get an afternoon off.

PRIVATE ENTERPRISE DOING A PRETTY FAIR JOB

Premiums written by health and accident companies in 1945 totalled approximately $585,000,000, an increase of 13 per cent over 1944, the Health and Accident Underwriters Conference has reported. It was estimated at about 42,000,000 persons now have some form of accident and health protection.

All of which indicates the American public is conscious of the benefits of this type of insurance protection; that a large proportion are willing to purchase this protection, voluntarily and from non-governmental agencies; and that the cry on the part of some that "compulsion" is the only way to spread protection to the wage earners and their families is simply sales talk on the part of those who want government to do everything for everybody.

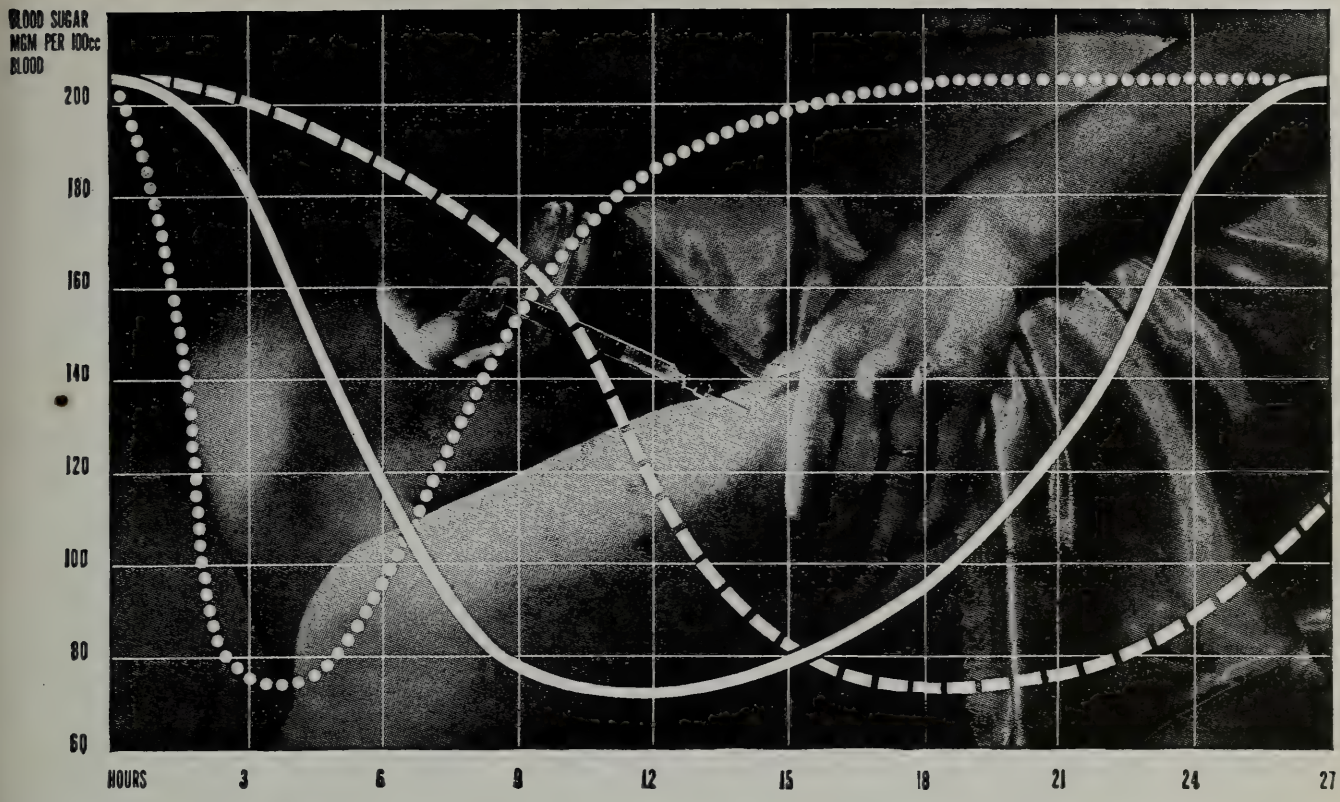
Plan for Temporary Approval of Residencies Announced

Because of the large number of applications for approval of residency training programs submitted by hospitals developing these programs in response to demand for training by returning medical officers, the Council on Medical Education and Hospitals of the A.M.A. has approved a plan for the temporary approval of residencies.

The authority to grant temporary approval will for the time being be delegated to the secretary of the Council subject to the concurrence by a representative of the appropriate American board, which will also consider new residencies for temporary approval.

Consideration will be based on information from the hospital concerning personnel, facilities, and educational program, without immediate inspection. Subsequently, the usual inspection procedure by the Council's staff will be conducted, and the Council will consider the temporarily approved hospital for transfer to the regularly approved list, or withdrawal of temporary approval, subject to the concurrence of the appropriate American board.

In event of the latter action, credit toward board certification will be given to physicians for that part of their training received while the institution was on a temporary approval status, and they will have a reasonable length of time to obtain an acceptable residency, without loss of time credit.



Today, there are 3 types of insulin...

THE PHYSICIAN now has a new intermediate-acting type of insulin with which to treat his diabetic patients—'Wellcome' Globin Insulin with Zinc. Originally there was only quick-acting, short-lived insulin. Then came a slow-acting, long-lived form. And now with Globin Insulin he has a moderately rapid-acting agent which persists for sixteen hours or more, enough to cover the period of maximum carbohydrate intake. This activity is sufficiently diminished by night to minimize nocturnal reactions. Physicians will do well to consider the advantages of this new third insulin for their diabetic patients.

'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its freedom from allergenic properties.

Accepted by the Council on Pharmacy and Chemistry, American Medical Association. Developed in the Wellcome Research Laboratories, Tuckahoe, New York. U.S. Patent No. 2,161,198. Available in vials of 10 cc., 80 units in 1 cc., and vials of 10 cc., 40 units in 1 cc. Literature on request. 'Wellcome' trademark registered.

'WELLCOME'
Globin Insulin
WITH ZINC

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In Memoriam

David Percy Bowden, M.D., Cleveland; University of Wooster Medical Department, Cleveland, 1912; aged 63; died Feb. 16; former member of the Ohio State Medical Association and the American Medical Association. Dr. Bowden practiced both medicine and law in Cleveland for more than 30 years. He was a 32nd Degree Mason. Surviving are his widow and a son. Another son was lost in action in the Philippines in April, 1945.

Arleigh Clinton Delaplane, M.D., Cincinnati; Baltimore Medical College, 1902; aged 66; died Feb. 13; member of the Ohio State Medical Association and Fellow of the American Medical Association; member of the American Heart Association. Dr. Delaplane served with the medical department of the Pennsylvania Railroad for 40 years. He was a member of the Catholic Church and the Elks Lodge. His widow survives.

Frank C. Franke, M.D., Cleveland; Western Reserve University School of Medicine, 1880; aged 87; died March 6; former member of the Ohio State Medical Association and the American Medical Association. Dr. Franke had retired in 1923 after having practiced medicine in Cleveland for 42 years. For many years he was in charge of the infirmary at City Hospital in Cleveland. He is survived by a son and two daughters.

Stephen Greenfield, M.D., Akron; New York University College of Medicine, 1909; aged 59; died Feb. 19; member of the Ohio State Medical Association and Fellow of the American Medical Association. Dr. Greenfield had practiced medicine in Akron for 29 years. He was formerly a company physician at the Goodyear Tire and Rubber Company. He later joined the city health department, where he aided in the organization of the venereal disease clinic. He belonged to the Akron Liedertafel and was head of the medical examining committee of Selective Service board No. 5, Akron. Surviving are his widow, a son, a daughter, two brothers, and three sisters.

Philip C. Leavenworth, M.D., Cleveland; Western Reserve University School of Medicine, 1944; aged 26; died Feb. 25. Dr. Leavenworth, a resident in obstetrics and gynecology at McDonald House, a branch of University Hospitals, was killed while returning from a call, when his automobile crashed through a guard rail into the Cuyahoga River in Cleveland. Surviving are his widow, two daughters, his parents, Dr. and Mrs. Loyal E. Leavenworth of Canton, and two brothers.

Donald Blair Lowe, M.D., Akron; Western Reserve University School of Medicine, 1912; aged 63; died March 2; member of the Ohio State Medical Association; Fellow of the American Medical Association and the American College of Physicians. A native of Kingsville, Ohio, Dr. Lowe had been medical director of the B. F. Goodrich Company since 1915. He had been a member of the Summit County Medical Society since 1916; its president in 1939, and delegate in 1935, 1936, and 1937. He was chairman of the Ohio State Medical Association's sub-committee on Workmen's Compensation from 1936 through 1939; and served on the Public Relations and Economics Committee from 1936 through 1940, the last year as chairman.

Dr. Lowe was president of the American Association of Industrial Physicians and Surgeons in 1932 and 1933 and a former chief of staff of City Hospital in Akron. He was a member of the American Public Health Association and Delta Upsilon fraternity. His friends and associates are planning a memorial scholarship in his name to carry on his activity of assistance to young medical students. He leaves his widow, one son, and a daughter.

James Howe McLachlin, M.D., Cincinnati; Eclectic Medical College, Cincinnati, 1919; aged 51; died March 3. Dr. McLachlin was a member of the staff at Bethesda Hospital in Cincinnati, and had studied in London, Budapest, and Vienna. Surviving are his widow, his mother, and three brothers.

William A. McMichael, M.D., Keene; Medical College of Ohio, Cincinnati, 1897; aged 77; died March 4; former member of the Ohio State Medical Association and the American Medical Association. Dr. McMichael had practiced medicine in Keene for 49 years and had served for 11 years in the Coshocton County health department. He was a member of the Presbyterian Church. His widow survives.

William Nelson Mundy, M.D., Forest; Eclectic Medical College, Cincinnati, 1883; aged 86; died Feb. 28; former member of the Ohio State Medical Association and the American Medical Association. Dr. Mundy was one of northwestern Ohio's oldest practicing physicians, and had maintained an office in Forest for 60 years. He was president of the Hardin County Medical Society in 1925; delegate in 1927, and secretary-treasurer from 1930 through 1936. Author of a book on the diseases of children, Dr. Mundy was formerly a professor in that field at his alma mater. In civic affairs, he was first chairman of the county Red Cross Chapter; instrumental in bringing Forest its library; a member of the library board; former member of the Forest and Hardin County school boards; an elder of the Presbyterian



Old enough to be his grand-folks -- yet the physician's kindly understanding of their geriatric problems inspires their fullest confidence.

Essential to the physician's confident manner is his reliance on medicines of unvarying quality. His confidence is well-placed when his prescriptions specify "Warren-Teed."

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Church and for 50 years Sunday School Superintendent; treasurer of the Marion Presbytery; and past grand patriarch of Grand Encampment of Odd Fellows of Ohio. Surviving are two sons, Dr. Carll S. Mundy, Toledo, Chairman of the Ohio State Medical Association's Committee on Rural Health, and Giles J. Mundy, Toledo.

Charles Wright Stoughton, M.D., Westerville; Ohio Medical University, Columbus, 1901; aged 73; died Feb. 23. Dr. Stoughton had practiced medicine in Westerville since 1908, and previous to that time had practiced in Homer for a year and at Croton for six. He was a member of the United Brethren Church and the Masonic Lodge. Surviving are his widow and one son.

Abraham Thomas, M.D., Cleveland; Meharry Medical College, Nashville, 1925; aged 59; died March 2. Dr. Thomas was a native of Jamaica, B.W.I. He had practiced medicine in Cleveland for 18 years. Surviving are his widow, two sons, a daughter, three brothers and a sister.

Arba Brown Tubbs, M.D., Cadiz; College of Physicians and Surgeons of Baltimore, 1897; aged 76; died Feb. 1; member of the Ohio State Medical Association and the American Medical Association. Dr. Tubbs, who had served both as health commissioner and coroner of Harrison County, practiced medicine in Ohio for over 50 years. He was a member of the United Presbyterian Church and the Masonic Lodge. Surviving are his widow, two step-children, and one brother.

Louis Umstetter, M.D., Cleveland; University of Wooster Medical Department, Cleveland, 1885; aged 85; died Feb. 21. Dr. Umstetter had practiced in Cleveland from about 1885 until his retirement a few years ago. He had studied abroad in Berlin, Vienna, and Heidelberg. He is survived by his widow.

Walter Lee Wheat, M.D., Zanesville; Meharry Medical College, Nashville, 1944; aged 32; died Feb. 25. Dr. Wheat was killed in an auto crash while en route from Dayton to Zanesville. He had recently been released from Army service and had established practice in Zanesville.

Lorne William Yule, M.D., Columbus; Queen's University Faculty of Medicine, Kingston, Ontario, 1908; aged 65; died Feb. 17; member of the Ohio State Medical Association; Fellow of the American Medical Association; diplomate of the American Board of Psychiatry and Neurology; and member of the American Psychiatric Association. At the time of his death Dr. Yule was serving as assistant superintendent and physician at the State Institution for the Feeble-Minded at Columbus. He was a former superintendent of the State Institution at Apple Creek, and had served on the staffs of the Cleveland and Massilon State Hospitals. Dr. Yule was a member of the Masonic and Knights Templar Lodges. Surviving are his widow, a brother, and a sister.

Cleveland Offers Refresher Work in Obstetrics and Pediatrics

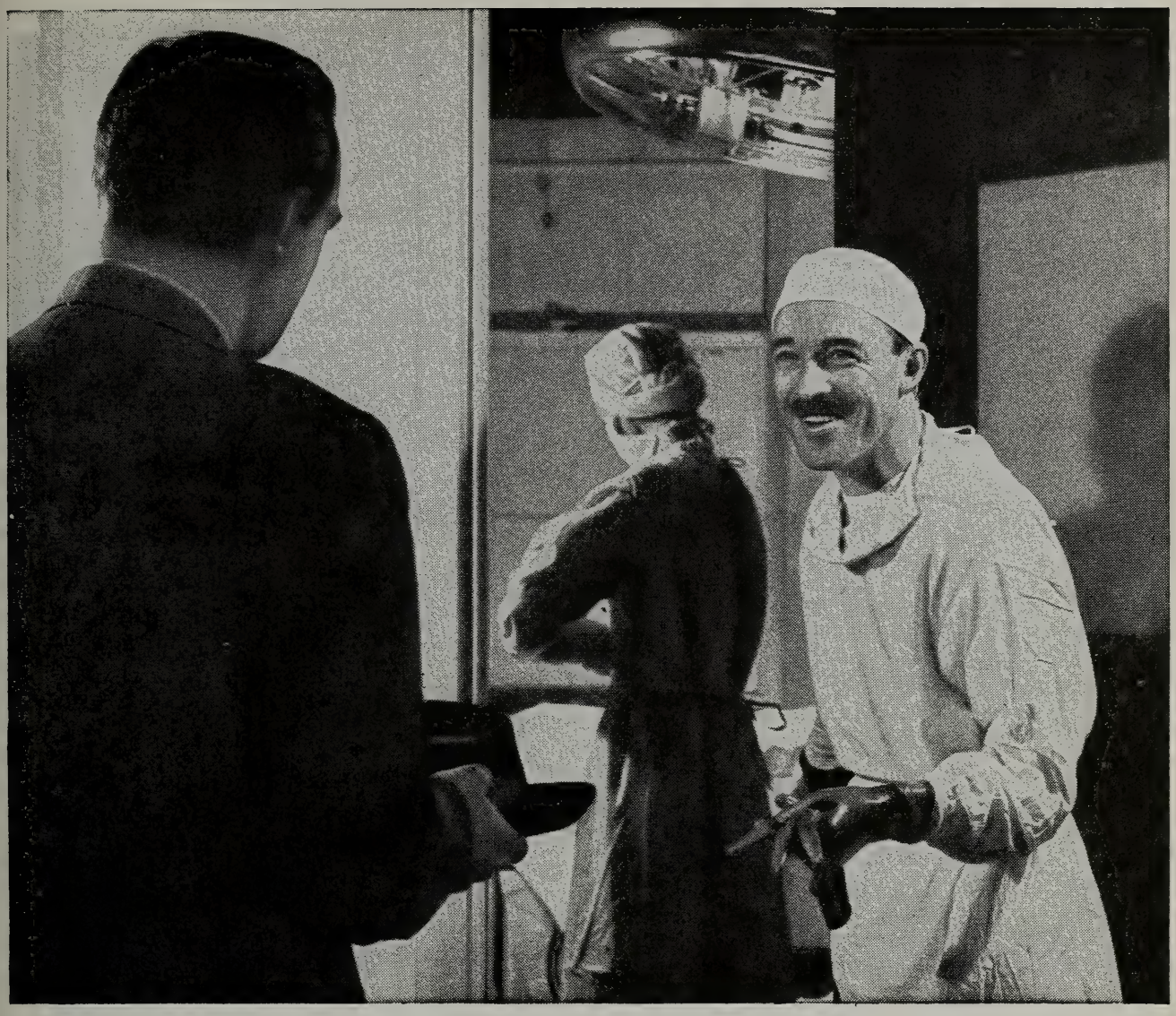
In connection with National Child Health Day a refresher course in obstetrics and pediatrics will be held April 29-May 1, 1946, at the Cleveland Academy of Medicine. The course will be sponsored by the Academy, the Western Reserve University School of Medicine, and the Division of Health of Cleveland.

Registration will begin at 12 noon on April 29, with lectures from 2 to 4:30 p.m. Clinics at University Hospitals will last from 4:30 to 5:30 p.m., and at 7:15 p.m. a tour of the Cleveland Health Museum is scheduled.

On April 30, there will be lectures from 9 a.m. until 12 noon. They will begin again at 1:15 p.m. and continue until the clinics at 4:30 p.m. At 8 p.m. there will be a joint meeting with the Academy of Medicine. On May 1, there will be lectures from 9 a.m. until noon, followed by luncheon, including two short lectures from 12:15 p.m. to 2:30 p.m.

No registration fee will be charged. Hotel reservations should be made immediately and all correspondence should be addressed to Dr. A. W. Thomas, Room 27, City Hall, Cleveland 14.

Those who will lecture at the seminar are: C. A. Aldrich, M.D., Mayo Clinic, Rochester, Minnesota; Nicholson J. Eastman, M.D., professor of obstetrics, Johns Hopkins Medical School; Bruno Gebhard, M.D., director of Cleveland Health Museum; H. J. Gerstenberger, M.D., professor emeritus of pediatrics, Western Reserve University, School of Medicine; Walter Heymann, M.D., assistant clinical professor of pediatrics, Western Reserve University, School of Medicine; Thomas Hill, D.D.S., professor of clinical oral hygiene and therapeutics, Western Reserve University, School of Medicine; John W. Holloway, M.D., assistant clinical professor of surgery, Western Reserve University, School of Medicine; A. J. Horesh, M.D., assistant clinical professor of pediatrics, Western Reserve University, School of Medicine; Donovan McCune, M.D., professor of pediatrics, Columbia University; Charles F. McKhann, M.D., professor of pediatrics, Western Reserve University, School of Medicine; Norman F. Miller, M.D., professor of obstetrics and gynecology, University of Michigan, School of Medicine; John A. Toomey, M.D., professor of clinical pediatrics and contagious disease, Western Reserve University, School of Medicine; Borden S. Veeder, M.D., Editor, *The Journal of Pediatrics;* James L. Wilson, M.D., professor of pediatrics, University of Michigan, School of Medicine; and C. W. Wyckoff, M.D., chairman of the Health Education Committee of the Cleveland Academy of Medicine.



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—and his life expectancy is brighter, and longer by 15 years —thanks to medicine's "men in white"

● Cold figures . . . with a warm, wonderful significance. Yes, the figures on increased life expectancy tell as much as a five-foot shelf of volumes on the amazing strides modern medical science has made in protecting and prolonging human life.



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than any other cigarette

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Activities of County Societies

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

ADAMS

Dr. Clifford G. Foor, Hillsboro, discussed "Surgical Diseases and Injuries of the Chest", and Dr. William T. Foley, Cincinnati, spoke on "Office Treatment of Gynecologic Conditions" at the March 27 meeting of the Adams County Medical Society, held at West Union.—Hazel L. Sproull, M.D., secy.

BROWN

Dr. R. B. Hannah, Georgetown, is president, and Dr. George P. Tyler, Jr., secretary, of the Brown County Medical Society for 1946.

BUTLER

At the dinner meeting of the Butler County Medical Society, held February 28 at the Hamilton City Club, two seminars were conducted. Blood protein was discussed in the medical seminar, with Dr. Lee Brown of Hamilton as monitor. Water, salts, and proteins were discussed in the surgical section, with Dr. Walter Reese of Middletown as monitor.—Bulletin.

CLINTON

Health and hospitalization in Clinton County were studied at a special meeting of the Medical Society, local businessmen, and officers of the Rural Policy Group of that county in Wilmington February 14.

Dr. William L. Regan, Wilmington, spoke at the March 5 meeting of the society on the subject "Recent Advances in Therapeutics". There was a general discussion regarding the proposed increase in State dues.—R. W. DeCrow, M.D., secy.

HAMILTON

The ninth Roger S. Morris Memorial Lecture, under the auspices of the Department of Internal Medicine, University of Cincinnati College of Medicine, was conducted March 5 before the Academy of Medicine of Cincinnati. The speaker, a native of Cincinnati, was Dr. Louis Harry Newburgh, professor of clinical investigation in internal medicine, University of Michigan, Ann Arbor. His topic was "Sodium Metabolism".

On March 19, Dr. Sumner L. Koch, assistant professor of surgery, Northwestern University Medical School, Chicago, spoke to the academy on "Injuries of the Nerves and Tendons of the Hand".—Bulletin.

WARREN

The following physicians are officers of the Warren County Medical Society for 1946: Dr. O. W. Hoffman, Franklin, pres.; Dr. Robert M. Wilson, Franklin, pres.-elect and delegate; Dr. James H. Arnold, Lebanon, secy.; Dr. Mary Cook, Waynesville, treas.; Dr. A. E. Stout, Waynesville, alternate.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

DARKE

The Darke County Medical Society heard Dr. G. A. Nicoll, Dayton, discuss "X-ray Diagnosis of Gastrointestinal Conditions" at the March 19 meeting of the group at Wayne Hospital, Greenville.—W. D. Bishop, M.D., secy.

GREENE

The following Xenia physicians are officers of the Greene County Medical Society for 1946: Dr. Harold Ray, pres.; Dr. Roger Henderson, pres.-elect; Dr. Nancy Lautzenheiser, secy.-treas.; Dr. C. G. McPherson, delegate; Dr. P. D. Espey, alternate.

MIAMI

"Cardiac Emergencies, Diagnosis and Treatment" was the subject of a paper presented by Dr. A. F. Kuhl, Dayton, before the March 1 meeting of the Miami County Medical Society. In April the society will give a dinner in honor of members who were in military service in World War II. The speaker will be Dr. L. H. Schriver, Cincinnati, president of the Ohio State Medical Association. Plans are under way to reactivate the Woman's Auxiliary to the Miami Society.—G. A. Woodhouse, M.D., secy.

MONTGOMERY

Dr. Joseph P. Evans, associate professor of surgery, University of Cincinnati College of Medicine, spoke on "Head Injuries" at the March 1 meeting of the Montgomery County Medical Society in Dayton. General practice and surgical sections have recently been organized in the society, and an eye, ear, nose, and throat section is expected to form soon.—N. E. Leyda, M.D., pres.

Third District

(COUNCILOR: GUY E. NOBLE, M.D., ST. MARYS)

ALLEN

Dr. Clyde Dawson, Columbus, spoke on "Low Back Pain and Rupture of the Intervertebral Disc" at the February 19 meeting of the Academy of Medicine of Lima and Allen County.—H. H. Brueckner, M.D., secy.

CRAWFORD

The following Bucyrus physicians are officers of the Crawford County Medical Society for 1946: Dr. R. J. Caton, pres.; Dr. C. A. Lingenfelter, vice-pres.; Dr. W. G. Carlisle, secy.-treas.; Dr. D. G. Arnold, delegate; Dr. E. R. Schoolfield, alternate.

LOGAN

The Logan County Medical Society met March 1 at the Hotel Logan, Bellefontaine. Dr.

YOU CAN'T OVERRATE THE VALUE OF CONTROL



Everyone can see the need for control measures against *obvious* dangers. But dramatic and constant campaigning is necessary to win public support in the fight against the unseen menace of cancer. Interest must be awakened and education conducted to enlist the public co-operation requisite to success. This challenging work is the responsibility of the Field Army of the American Cancer Society.

To give appropriate significance to these efforts and to focus nation-wide attention on this vital problem, Congress has designated April, "Cancer Control Month." And again this Spring, as in each drive spearheading the next year's activities, the Field Army's straightforward appeal to all Americans is: "GIVE, to Conquer Cancer."

Once more, over 10,000 Rexall Drug Stores across the country unite in behalf of this cause. Urging Americans to heed the Society's plea, these stores contribute facilities for distribution of literature cautioning "Consult your doctor" at the first moment of cancer's "danger signals."

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PORTLAND • PITTSBURGH • FT. WORTH • NOTTINGHAM • TORONTO • SO. AFRICA

Hobart L. Mikesell, West Liberty, was chairman of the program.—News clipping.

MARION

At the March 5 meeting of the Marion County Academy of Medicine, the members expressed their willingness to care for veterans under the newly proposed plan of the Veterans' Administration, which allows the veteran to receive care from a physician of his own choice. Dr. E. L. Brady was named to represent the Academy on a committee on tuberculosis legislation. A motion picture on "Amebiasis" was presented by Dr. William Pennington.

Fourth District

(COUNCILOR: A. A. BRINDLEY, M.D., TOLEDO)

LUCAS

At the March 1 general meeting of the Academy of Medicine of Toledo and Lucas County, George R. Effler, Toledo, discussed the subject "The Doctor and the Law".

Mar. 8—Section of Pathology, Experimental Medicine and Bacteriology: "Pinworm Infection of the Appendix", Dr. Francis R. Canelli, Mercy Hospital, Toledo.

Mar. 15—Medical Section: "Heart Disease", Dr. William D. Straud, professor of cardiology, University of Pennsylvania Graduate School of Medicine, Philadelphia.

Mar. 22—Surgical Section: "Treatment of Facial Injuries and Deformities", Dr. Claire L. Straith, chief of division of plastic surgery, Harper Hospital, Detroit.

Mar. 29—Eye, Ear, Nose, and Throat Section: "Bronchiectasis—Etiology, Pathology, and New Methods in Treatment with Special Reference to the Use of Penicillin Aerosol and Intrabronchial Instillations", Dr. W. W. Randolph, Toledo.—Bulletin.

OTTAWA

The Ottawa County Medical Society has elected the following officers for 1946: Dr. Alfred D. Miessner, Port Clinton, pres.; Dr. Cyrus R. Wood, Port Clinton, pres.-elect; Dr. Harry O. Beeman, Port Clinton, secy.-treas. and alternate; Dr. George A. Boon, Oak Harbor, delegate.

SANDUSKY

Three physicians were accepted by the Sandusky County Medical Society at a meeting held March 5 at the Memorial Hospital, Fremont: Dr. Allen Newman, Fremont, Dr. Ervin Koons, Fremont, and Dr. Frederick Mitchell, Bellevue.—News clipping.

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

ASHTABULA

Fifteen physicians who represented Ashtabula County in military service during the war and returned to that county to practice were honored recently at a party held at the Hotel Ashtabula by the County Medical Society.—News clipping.

CUYAHOGA

The regular meeting of the Academy of Medicine of Cleveland, held March 15 in the Medical Library Auditorium, was addressed by Dr. Russell L. Cecil, professor of clinical medicine, Cornell University Medical School, New York City. The subject of Dr. Cecil's talk was "The Modern Treatment of Arthritis".

Mar. 1—Clinical and Pathological Section, Huron Road Hospital: "A Case of Brain Tumor Associated with Pregnancy", Dr. A. G. Cummings; "A Case of Ruptured Spleen", Dr. T. L. Laughlin; "A Case of Pulmonary Edema Following Spinal Anesthesia", Dr. A. J. Fisher; "A Case of Lipoid Pneumonia Following Hysterosalpingography", Dr. J. H. Atkins; "A Case of Pyometra Associated with Full Term Pregnancy", Dr. G. H. Irvin; "A Case of Carcinoma of the Cervix and Vagina in a Child", Dr. R. R. Renner; "An Unusual Complication in the Treatment of Ureteral Calculus", Dr. H. W. Brown, Jr.; "A Case of Patent Ductus Arteriosus" (with sound recordings), Drs. W. A. Sommerfield and F. S. Meck; "A Case of Resection of Sarcoma of the Mandible", Dr. A. H. Reed.

Mar. 8—Combined meeting, Experimental Medicine Section of the Academy and Cleveland Section of the Society for Experimental Biology and Medicine, at Institute of Pathology Amphitheater. Symposium on Experimental Shock: "Orientation and Brief Summary of Five Year Study", Dr. Carl J. Wiggers; "Electrocardiographic Changes in Hemorrhagic and Ischemic Compression", Drs. Jose Manrique and B. Pasternack; "Limb Blood Flow in Hemorrhagic Hypotension and Shock", Dr. Richard W. Eckstein; "Renal Blood Flow and Clearances in Hemorrhagic Shock", Ewald E. Selkurt, Ph.D.; "Circulatory Failure Induced by Partial Cerebral Ischemia", David F. Opdyke, Ph.D.

Mar. 20—Industrial Medicine and Orthopedic Section, Herrick Room, Medical Library: "Hand Injuries in the Southwest Pacific Theater" (with motion pictures), Dr. D. M. Glover; "Pneumography in the Diagnosis of Internal Derangements of the Knee Joint", Dr. W. H. McGaw.

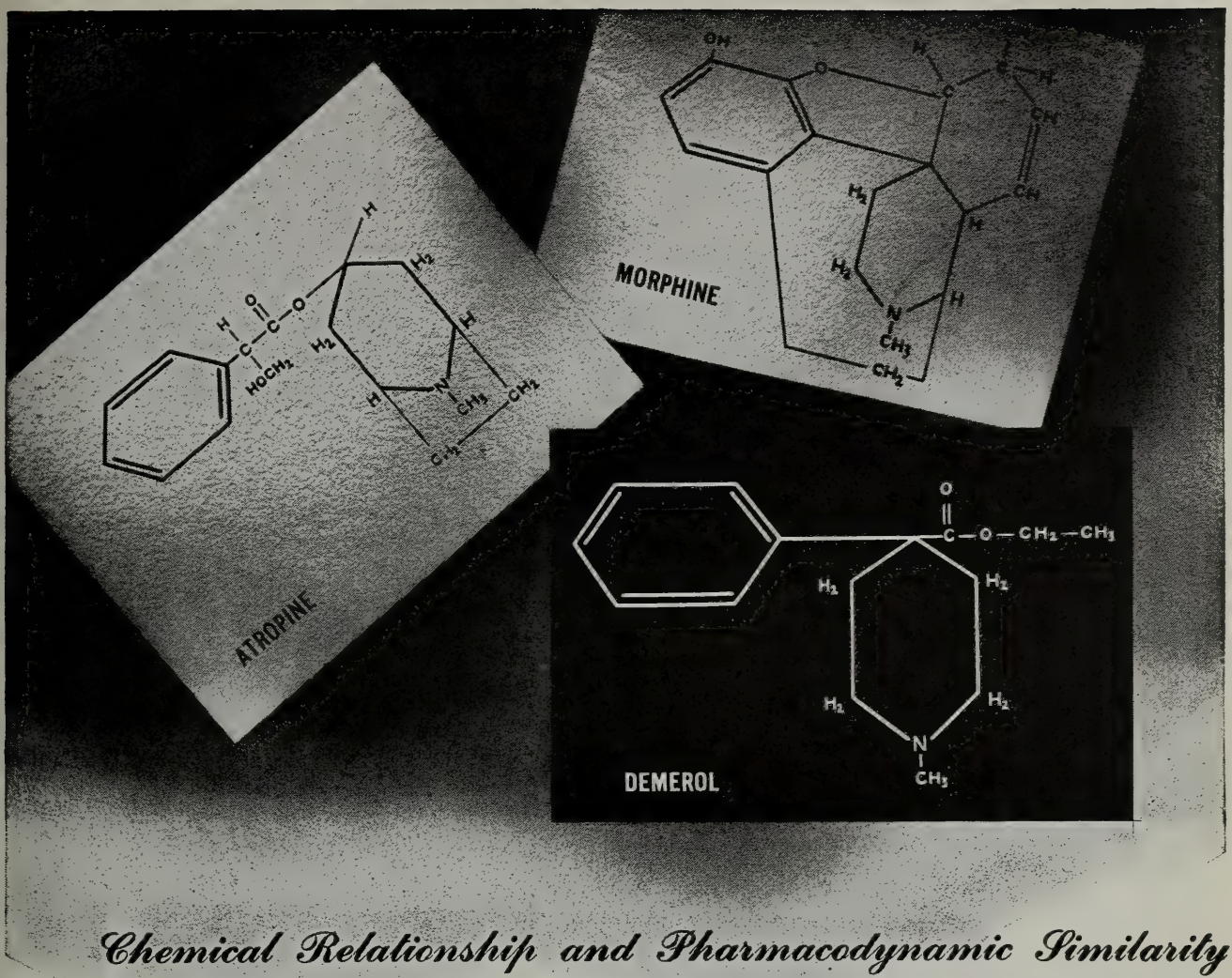
Mar. 27—Pediatrics Section, Herrick Room, Medical Library: Program presented by staff at Babies' and Children's Hospital.—Bulletin.

Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

MAHONING

Dr. Richard Hugh Lyons, associate professor, University of Michigan, spoke at the March 19



Chemical Relationship and Pharmacodynamic Similarity

A NEW SYNTHETIC

ANALGESIC — Demerol's analgesic power ranks between morphine and codeine.

SPASMOLYTIC — Demerol's spasmolytic action is similar to that of atropine.

SEDATIVE — Demerol's sedative effect is mild, but usually sufficient to allay restlessness and induce sleep.

PRACTICALLY NO RISK OF RESPIRATORY DEPRESSION

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HOW SUPPLIED — For oral use: Tablets of 50 mg., bottles of 25 and 100. For intramuscular injection: Ampuls of 2 cc. (100 mg.), boxes of 6 and 25, and vials of 30 cc. (50 mg. per 1 cc.).

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meeting of the Mahoning County Medical Society, held at the Youngstown Club.

PORTAGE

Dr. U. V. Portmann of the Cleveland Clinic spoke on the subject "Cancer of the Breast" before the March 7 meeting of the Portage County Medical Society, held at the Robinson Memorial Hospital in Ravenna.—Emily J. Widdecombe, M.D., secy.

STARK

"The Wagner-Murray-Dingell bill would be a big step toward the socialization of the people's wealth rather than a measure of social security", Ed Rowe, Akron, former 14th District U. S. Representative, told more than 200 physicians and their wives at the monthly meeting of the Stark County Medical Society, February 14, at the Elks Club in Canton.—News clipping.

SUMMIT

Dr. Argyl J. Beams, associate clinical professor of medicine at Western Reserve University Medical School spoke on "Newer Treatment of Cirrhosis of the Liver", at the March 5 meeting of the Summit County Medical Society, held at City Hospital, Akron.—Bulletin.

TRUMBULL

Dr. James Dickson of the Cleveland Clinic discussed hip fractures at the February 21 meeting of the Trumbull County Medical Society held at the Hotel Warner in Warren.—News clipping.

Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

CARROLL

The new officers of the Carroll County Medical Society are: Dr. W. G. Lyle, Minerva, pres. and delegate; Dr. S. L. Weir, Minerva, pres.-elect; Dr. P. S. Whiteleather, secy.-treas.; and Dr. L. W. Cellio, Carrollton, alternate.

COSHOCTON

The 1946 officers of the Coshocton County Medical Society, elected February 12 at Coshocton are: Dr. H. H. Schwindt, West Lafayette, pres.; Dr. R. E. Hopkins, Coshocton, vice-pres.; Dr. H. W. Lear, Coshocton, secy.-treas.; Dr. G. A. Foster, Coshocton, delegate; Dr. F. W. Craig, Coshocton, alternate.

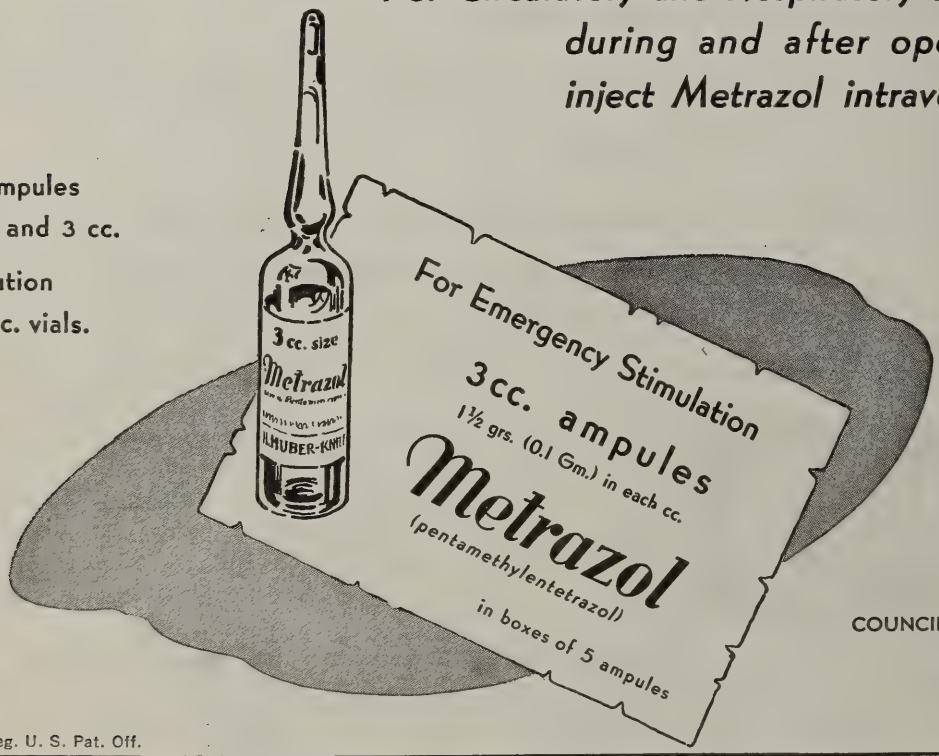
HARRISON

The February meeting of the Harrison County Medical Society and the Woman's Auxiliary was held at the home of Dr. and Mrs. E. L. Miller, Bowerston, with Dr. Gerald Vorhies, Scio, as the principal speaker. Dr. Vorhies discussed his experiences as commanding officer of a medical collecting company assigned to cavalry on the European front from shortly after D-Day to V-E Day. Dr. Carl A. Lincke, district councilor, spoke on the Ohio Medical Indemnity, Inc., voluntary medical prepayment plan. Mrs. W. W. H. Curtis, Dennison, past president of the Woman's

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Auxiliary to the Ohio State Medical Association, also spoke.—News clipping.

JEFFERSON

Formation of an Ohio Valley Academy of Medicine embracing Jefferson and Harrison counties in Ohio and Brooke and Hancock counties in West Virginia, was discussed by the Jefferson County Medical Society during the February 19 meeting at Ohio Valley Hospital. Dr. F. B. Harrington, Steubenville, was named representative of the Jefferson County group to discuss the plan with the other counties involved. Speakers at the meeting were Dr. Charles Hershey of the Wheeling Clinic who discussed "Thrombo Phlebitis", and Dr. D. A. MacGregor, of the same institution, who spoke on medical legislation.—News clipping.

Eighth District

(COUNCILOR: GEORGE F. SWAN, M.D., CAMBRIDGE)

ATHENS

Dr. T. H. Morgan is president, and Dr. C. R. Hoskins, secretary, of the Athens County Medical Society for 1946. Both physicians are residents of Athens.

GUERNSEY

At the February 7 meeting of the Guernsey County Medical Society, Capt. Lucien E. Morris, Medical Corps, U.S. Army, chief of the anesthesia and operating room section of Fletcher General Hospital, spoke on "Anesthesia". Capt. Morris and Major James R. Raines, also of Fletcher General Hospital, were accepted as members of the society at the same meeting. Dr. Reo Swan conducted a discussion on the topic, "The Diagnosis and Prognosis of Bundle Branch Block", at the February 21 meeting of the organization in Cambridge. At the March 7 meeting, Dr. J. D. Knapp spoke on "The Eye". Dr. Knapp had experience in eye work while in military service in Africa.—M. S. Lawrence, M.D., secy.

MORGAN

The following physicians have been named officers of the Morgan County Medical Society for 1946: Dr. A. A. Coulson, McConnelsville, pres.; Dr. Galen Rex, McConnelsville, secy.; Dr. A. H. Whitacre, Chesterhill, delegate; Dr. C. E. Northrup, McConnelsville, alternate.

MUSKINGUM

The officers of the Muskingum County Academy of Medicine for the ensuing year are: Dr. A. C. Ormond, Zanesville, pres.; Dr. L. P. Cassady, East Fultonham, pres.-elect; Dr. B. T. Hagen, Zanesville, secy.-treas; Dr. M. A. Loebell, Zanesville, delegate; Dr. C. F. Sisk, Zanesville, alternate. The March 6 meeting of the academy was held at the University Club Rooms in Zanesville, with Drs. D. G. Caudy and Kurt Eichwald of that city in charge of the program.

BLOOD — SPUTUM
ALLERGY — EFFUSIONS
URINALYSIS — FECES-VACCINES
BLOOD CHEMISTRY — X-RAY DIAGNOSIS
THROAT CULTURES — PREGNANCY TESTS
STOMACH CONTENTS — BASAL METABOLISM
SURGICAL PATHOLOGY — PNEUMOCOCCIC TYPING
AGGLUTINATION TESTS — AUTOGENOUS VACCINES
ELECTROCARDIOGRAPHY — PREMARITAL SEROLOGY
WASSERMAN & KAHN TESTS — DARK FIELD-SPIROCHETA

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WASHINGTON

At the February 13 meeting of the Washington County Medical Society, Dr. T. R. Mattocks, Marietta, was selected as chairman of the medical staff of Memorial Hospital in that city. Other physicians chosen, all from Marietta, were: Dr. W. S. Hawn, vice-chairman; Dr. E. W. Hill, Jr., secy. Dr. Hawn, Dr. N. M. LaBarre, and Dr. C. A. S. Williams were named to the executive committee. Guest speaker for the evening was Mrs. Harriet Rahn, R.N., superintendent of the hospital.

Tenth District

(COUNCILOR: H. M. CLODFELTER, M.D., COLUMBUS)

FRANKLIN

Dr. John E. Brown, Jr., Columbus, discussed the prevention and control of diphtheria from the physician's standpoint at the March 4 meeting of the Columbus Academy of Medicine. Dr. Henry Wilson, head of the department of infectious disease, University Hospital, Columbus, spoke on the clinical aspects of hospitalized cases. At the March 18 meeting, Dr. Paul H. Hollinger, department of otolaryngology, University of Illinois, spoke on "Bronchoscopy in Bronchopulmonary Diseases". Discussants were Drs. Hugh G. Beatty and Karl P. Klassen, Columbus.—Bulletin.

Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

HURON

Col. Benjamin A. Cockrell, chief medical officer, Veterans' Administration, Cleveland, was guest speaker at a joint meeting of the Huron County Medical and Dental Societies, February 27 at Norwalk. Col. Cockrell spoke on the new program of local medical and dental treatment of veterans.—George F. Linn, M.D., secy.

LORAIN

At the March 12 meeting of the Lorain County Medical Society, Captain Courtney Kirby, Elyria, spoke on the "Role of the Veterans' Service Center and Discussion of the Medical and Dental Care of Veterans". The meeting was held at the Castle-on-the-Lake, Lorain.—L. H. Trufant, M.D., secy.

WOMAN'S AUXILIARY NEWS

BY MRS. FRED W. BROSIUS, MIDDLETOWN)
Chairman, Publicity Committee

BUTLER

The Woman's Auxiliary to the Butler County Medical Society met at the Manchester Hotel, Middletown, for luncheon on February 26 with 38 members present. During the brief business session members voted to provide funds to furnish a room in the new Nurses' Residence at Middletown Hospital and one in Mercy Hospital Hamilton.

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The following nominating committee was appointed: Mrs. C. J. Chamberlin, Mrs. W. H. Williams, Mrs. L. H. Skimming, Mrs. H. J. Baker, and Mrs. E. T. Storer. Tax stamps were collected by the Ways and Means Committee and 1,000 circulars obtained from the Summit County Auxiliary were distributed to members to acquaint the public with the defects of the Wagner-Murray-Dingell Bill.

Mrs. Roswell S. Fidler, president of the Woman's Auxiliary to the Ohio State Medical Association, was introduced by Mrs. Fred Brosius. Mrs. Fidler spoke on recent developments of the Wagner Bill and Mrs. Edna Rymal Cox gave an interesting talk on interior decorating. Hostesses were Mrs. C. T. Atkinson, Mrs. L. H. Skimming, Mrs. Walter Reese, and Mrs. M. H. Weinstein.

CLINTON

At a luncheon meeting of physicians' wives of Clinton County March 5, it was unanimously voted to organize an auxiliary to the Clinton County Medical Society. Officers are: Mrs. Kelly Hale, Wilmington, pres.; Mrs. C. E. Kinzel, Wilmington, secy.; Mrs. S. A. Crabtree, Martinsville, treas.

Mrs. Roswell Fidler, Columbus, president of the Auxiliary to the State Medical Association, and Mrs. W. B. Roads, Hillsboro, district director, were present to assist in the organization meeting.

FRANKLIN

Phases of community life in which physicians' wives are participating were discussed at the March 18 meeting of the Woman's Auxiliary to the Columbus Academy of Medicine, held at the Columbus Gallery of Fine Arts. Mrs. George I. Nelson was in charge of the program, which was arranged by Mrs. Albert Frost. The following took part in the program: Mrs. J. F. Bateman, Mrs. H. C. A. Beach, Mrs. Ralph Hoffman, Mrs. Gilman Kirk, Mrs. Miner Seymour, and Mrs. Earl Ryan.

KNOX

The Woman's Auxiliary to the Knox County Medical Society met recently at the home of Mrs. Richard Gomer. Mrs. Julius Shamansky was co-hostess. During the business session, presided over by Mrs. John Drake, the group urged the hospital guild members to resume sewing at the hospitals. Mrs. Shamansky spoke on her recent trip to Mexico illustrating her talk with technicolor movies.

LUCAS

At a joint dinner meeting of the Lucas County Medical Society and the Auxiliary held at the Commodore Perry Hotel, Toledo, February 28, Grove Patterson, editor of the *Toledo Blade*, addressed the group on his recent experiences in the Far East. The fact that there were over 360 reservations, speaks well for the

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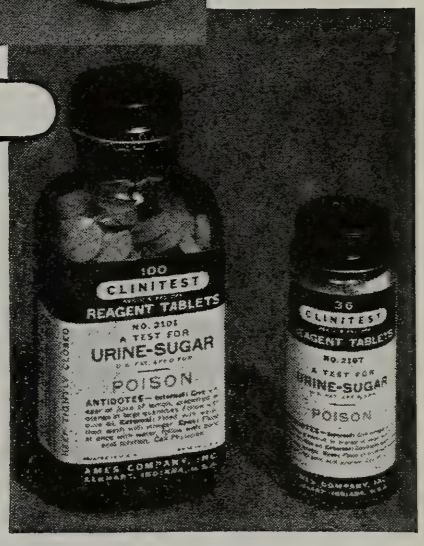


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committee on arrangements. Dancing was enjoyed following the program.

MARION

Members of the Woman's Auxiliary to the Marion County Academy of Medicine met for luncheon February 18 at Hotel Harding. Dr. Margaret Pennington, guest speaker, chose as her topic, "Women in Medicine". She pointed out how women doctors helped fill the gap when the war drew heavily on the medical profession. This helped break down some of the old barriers against women in medicine. Mrs. Clare Smith presided at the meeting. Publicity chairman is Mrs. Clarence Weber.

ROSS

At a dinner meeting held in Chillicothe March 7, the Woman's Auxiliary to the Ross County Academy of Medicine discussed the sponsorship of a rummage sale to raise funds for a wheeled stretcher for the Chillicothe hospital, according to a report from Mrs. Glen Nisley.

SCIOTO

Twenty-five members were present at the February meeting of the Woman's Auxiliary to the Hempstead Academy of Medicine, held at the home of Mrs. Gilbert Micklethwaite. The following officers were elected for the ensuing year: Mrs. Wells McCann, pres.; Mrs. Milton Levine, pres.-elect; Mrs. L. B. Hatch, vice-pres.; Mrs. George D. Blume, secy.; Mrs. George W Martin, treas. Members-at-large are Mrs. Harry Rapp and Mrs. Clyde Everett.

The nominating committee was Mrs. W. G. Cheney, chairman, Mrs. Clyde Fitch, Mrs. Carl Braunlin, Mrs. T. C. Crawford, and Mrs. Levine. The program was conducted by Mrs. William E. Gault. A Valentine quiz and a short history of St. Valentine were enjoyed by the members. Mrs. Glen Brock, guest speaker, delighted the group with several clever readings. The hostess and her committee served refreshments during the social hour.

WASHINGTON

The Woman's Auxiliary to the Washington County Medical Society met for a dinner at the Betsey Mills Club, February 13. Mrs. Eldon H. Schafer, an Army Nurse in the ETO, related some of her experiences while on duty with the 67th Evacuation Hospital in Europe.

Fire Fails To Stop Services

No interruption in service to patients was occasioned by the Rocky Glen Sanatorium due to the fire which caused an estimated $150,000 damage to the main building of the institution on March 7, according to Harry Mark, superintendent. Other buildings at the institution remained intact, and all patients escaped injury during the fire. Work on a new administration building will begin immediately.

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Four Weeks Course in General Surgery starting May 6, June 3, July 15.
One Week Surgery Colon and Rectum starting April 29, June 10.
One Week Course Thoracic Surgery starting April 22, May 13.

GYNECOLOGY—Two Weeks Intensive Course starting May 20, June 17. One Week Personal Course in Vaginal Approach to Pelvic Surgery starting May 13, June 10.

OBSTETRICS—Two Weeks Intensive Course starting May 6 and June 3.

MEDICINE—Two Weeks Intensive Course starting May 13.

ELECTROCARDIOGRAPHY & HEART DISEASE—Two Weeks Intensive Course starting August 5.

GASTROSCOPY & GASTROENTEROLOGY—Two Weeks Personal Course June 3.

DERMATOLOGY & SYPHILOLOGY—Two Weeks Course starting May 20.

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GET ROOM IN 'FRISCO NOW

Ohio physicians planning to attend the 1946 Session of the American Medical Association in San Francisco, July 1-5, should write for hotel reservations immediately. Rooms will be at a premium. Reservations should be made through the Hotel Committee. Complete information and a reservation blank are being carried weekly in The Journal of the A.M.A.

Johns Hopkins Group to Address Youngstown P-G Assembly April 17

The Eighteenth Annual Postgraduate Assembly of the Mahoning County Medical Society will be held at Youngstown, Wednesday, April 17. Morning sessions will be at local hospitals with the afternoon and evening sessions at the Hotel Pick-Ohio. The following members of the faculty of Johns Hopkins University School of Medicine, Baltimore, will be the speakers: Dr. William R. Reinhoff, associate professor of surgery; Dr. Charles W. Wainright, associate professor of medicine; Dr. Leroy M. Polvogt, professor of laryngology and otology; Dr. Raymond E. Lenhart, associate in orthopedic surgery; Dr. Houston S. Everett, associate professor of gynecology. The registration fee of $5.00 includes dinner. All Ohio physicians are cordially invited to attend.

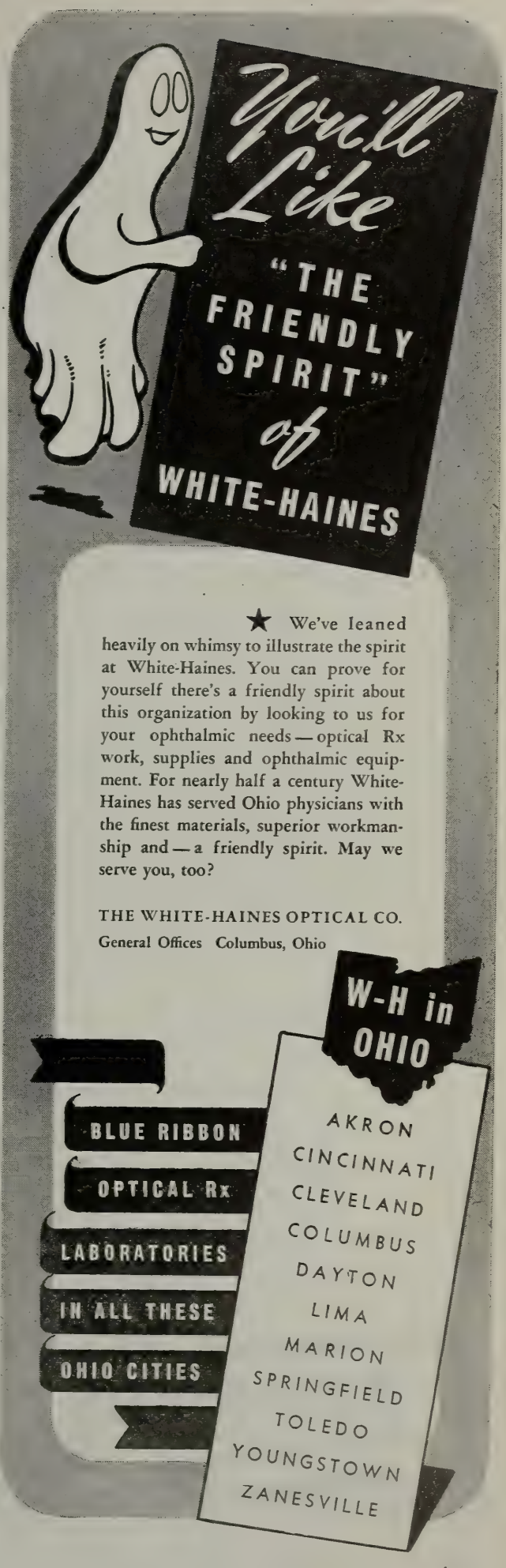
Northern Tri-State Meeting Planned

The Northern Tri-State Medical Association will hold its 72nd Annual Meeting at the Indiana Club, South Bend, Indiana, April 9, 1946.

Speakers will include Dr. George M. Rosenheimer, South Bend; Dr. Frederick F. Yonkman, Summit, New Jersey; Dr. Edith L. Potter, Chicago Lying-In Hospital; Dr. James L. Wilson, professor of pediatrics, University of Michigan, Ann Arbor; Dr. William H. Gordon, Detroit; Dean Clarence E. Manion, school of law, University of Notre Dame; Dr. Floyd T. Romberger, pres.-elect, Indiana State Medical Association; Dr. Cyrus C. Sturgis, professor of medicine, University of Michigan; Dr. F. W. Hoffbauer, department of medicine, University of Minnesota, and Dr. Walter L. Palmer, department of medicine, University of Chicago.

Warren—Dr. S. J. Shapiro was named president of the staff of St. Joseph's Hospital March 4. Dr. P. J. Fusco is vice-president, and Dr. Frank G. Guarnieri, secretary-treasurer.

Columbus—Dr. George J. Heer has been named to the board of directors of the Ohio National Bank.



Cooperation of Physicians In Diphtheria Control Program Is Urged

Dr. Roger E. Heering, director of the State Department of Health, has issued the following statement with regard to diphtheria in Ohio.

"Ohio had 773 cases of diphtheria with 69 deaths reported to the Division of Communicable Diseases of the Ohio Department of Health in 1945. For the first eight weeks in 1946, 276 cases of the disease have been reported. The figures for 1945 may be contrasted with 346 cases reported in 1944 with 32 deaths.

"In view of the fact that an effective method for the prevention of this disease with toxoid or alum precipitated toxoid is well known to physicians, this number of cases would appear entirely unnecessary. Physicians are urged to make a special effort to have parents provide for the immunization of their children long before school age. The seriousness of diphtheria and the importance of immunization should be emphasized continuously and by every means possible.

"Appropriate and early treatment are essential in preventing unnecessary deaths from this disease. Although laboratory confirmation of diagnosis is desirable, it is axiomatic that the physician should administer large doses of antitoxin in clinical cases of diphtheria without waiting for laboratory diagnosis. Dosage, either intramuscular or intravenous, depends on elapsed time and symptoms, but should be administered in amounts of 10,000, 20,000 or 40,000 units and repeated if necessary during the course of the disease. The administration of small dosages, such as the use of as little as 1,000 units which has occurred, is reprehensible. The wise and conscientious physician will give large doses of anti-toxin **early.**

"In order to assist local health departments in efforts to prevent dissemination of this disease, physicians are urged to report cases immediately, so that proper isolation and quarantine measures can be promptly and effectively instituted. For the same reason physicians should report the occurrence of diphtheria carriers to the health department."

Ottawa—Dr. E. B. Pedlow, Lima, was guest speaker at the March 4 meeting of the Kiwanis Club of Ottawa.

Bowling Green—Dr. R. N. Whitehead, recently released from the Naval Medical Corps, has been reappointed to the Bowling Green Board of Education. Dr. Whitehead had resigned when he entered the Navy.

Ashtabula—Dr. H. A. Tagett, Ashtabula, has been appointed as acting health commissioner of that city, in the absence of Dr. J. H. Park who is on leave.

CLASSIFIED ADVERTISEMENTS

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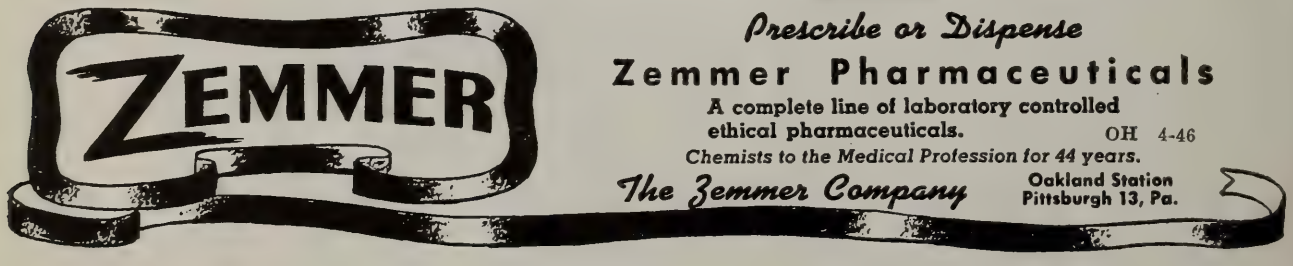
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Do You Know - - -

Don H. Ebright, Treasurer of the State of Ohio, has been named chairman of the State Campaign Committee of the Ohio Division of the American Cancer Society. E. S. Patterson, President of the First Central Trust Co., Akron, is vice-chairman. The goal of the committee in Ohio is $750,000.

* * *

"Public Relations in American Medicine" by Dr. Morris Fishbein in the February 23 issue of *The Journal of the American Medical Association*, pages 509-514, belongs on the "must" reading list of every physician and medical student.

* * *

Dr. Charles A. Doan, Dean, Ohio State University College of Medicine, was one of the guest speakers at the annual Spring clinical conference of the Dallas Southern Clinical Society, Dallas, Texas, March 18-21.

* * *

Dr. Carl A. Wilzbach, Cincinnati, has been appointed medical director for Region 2 (Pennsylvania, Maryland, Delaware, New Jersey, West Virginia, and Ohio) of the American Cancer Society, Inc. He has been on the state committee since the society was first organized in Ohio. Dr. Wilzbach is Health Commissioner of Cincinnati, and Chairman of the Committee on Education of the Ohio State Medical Association.

* * *

In an address to the Portsmouth Kiwanis Club, March 20, George H. Saville, Director of Public Relations, Ohio State Medical Association, contrasted the provisions of the Wagner-Murray-Dingell bill to the constructive program of the medical profession for better distribution of medical care.

* * *

Dr. Dwight M. Palmer, head of the department of neuropsychiatry, Ohio State University, College of Medicine, has been appointed part-time consultant in neuropsychiatry for the Veterans' Administration regional office in Columbus. The appointment was made February 22, and has been accepted with the approval of the dean of the college.

* * *

The Ohio Public Health Council approved on February 16 a set of regulations designated to cut down illnesses resulting from exposure to various toxic chemicals and metals in varied states as they might occur in mines and factories. These are the first regulations of that nature in Ohio. They will go into effect January 1, 1947.

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ANNUAL AUDIT OF BOOKS OF THE OHIO STATE MEDICAL ASSOCIATION AND THE OHIO STATE MEDICAL JOURNAL FOR YEAR ENDED DECEMBER 31, 1945, BY KELLER, KIRSCHNER, MARTIN & CLINGER, CERTIFIED PUBLIC ACCOUNTANTS, COLUMBUS, OHIO

OHIO STATE MEDICAL ASSOCIATION

Cash and Bonds on Hand, January 1, 1945:

Cash in Huntington National Bank	$ 13,626.63
Cash in Ohio National Bank	14,161.50
United States Treasury Bonds	71,000.00
Total cash and bonds on hand, Jan. 1, 1945	$ 98,788.13
Less sale of bonds August 13, 1945	31,000.00
Balance	$ 67,788.13

RECEIPTS

1945 Membership dues collected in 1945	$ 22,034.00	
1946 Membership dues collected in 1945	12,843.00	
Sale of bonds, face value	31,000.00	
Interest on U.S. Treasury bonds	2,883.98	
Exhibit space for 1946 Annual Meeting	2,907.00	
Refund on telephone and telegraph	119.85	
Refund by Ohio Medical Indemnity, Inc.	1,815.59	
Payment stopped on two checks	14.00	
Total cash received		73,617.42
Total To Be Accounted For		**$141,405.55**

DISBURSEMENTS

The Ohio State Medical Journal	$ 8,000.00	
Executive Secretary, salary	7,000.00	
Executive Secretary, expense	804.95	
Asst. Executive Secretary, salary	5,500.00	
Asst. Executive Secretary, expense	743.00	
President, expense	313.98	
Stenographers, salaries	3,717.00	
Council, expense	598.66	
Committee on Public Relations	1,256.02	
Committee on Industrial Health	13.96	
Committee on Education	25.67	
War Participation Committee	81.23	
Annual Meeting	60.27	
Stationery and supplies	469.48	
Postage, telephone, and telegraph	1,361.25	
Rent	2,400.00	
Auditing	100.00	
Employees' position bonds	30.00	
Industrial insurance	10.58	
Unemployment insurance	124.12	
Automobile liability insurance	40.00	
Safety deposit box rent	3.60	
American Med. Assn. delegates	219.47	
Refund on dues—military service and overpayments	67.00	
Committee on Medical Service Plans	2,071.04	
Checks reissued	14.00	
Refund cancellation, 1945 exhibits	2,237.50	
Investment—Ohio Medical Indemnity, Inc.	35,000.00	
Total disbursements		$ 72,262.78

Cash and Bonds on Hand December 31, 1945:

Cash in Huntington National Bank	$ 16,299.77	
Cash in Ohio National Bank	12,843.00	
U.S. Treasury Bonds: Series G, 12 years, 2½%	40,000.00	
Total cash and bonds on hand, Dec 31, 1945		69,142.77
Total Accounted for		**$141,405.55**

THE OHIO STATE MEDICAL JOURNAL

ASSETS

Current Assets, January 1, 1945:

Cash in Ohio National Bank	$ 4,933.78	
Cash in Petty Cash Account	10.00	
Accounts receivable (advertising)	1,708.03	
Total current assets		$ 6,651.81
Property Assets:		
Furniture and fixtures—depreciated value		2,108.99
Total Assets		**$ 8,760.80**

LIABILITIES AND SURPLUS

Current Liabilities:		
Subscriptions prepaid		$ 150.00
Surplus:		
Surplus at December 31, 1944	$ 5,761.18	
Add net profit for the year 1945	2,849.62	
Surplus at December 31, 1945		8,610.80
Total Liabilities and Surplus		**$ 8,760.80**

STATEMENT OF PROFIT AND LOSS

Revenue:		
Advertising		$ 22,786.95
Less:		
Commissions on advertising	$ 1,445.23	
Cash discounts	121.34	
Total deductions		1,566.57
Advertising revenue, net		$ 21,220.38
Ohio State Medical Association appropriation		8,000.00
Journal subscriptions and sales		378.33
Total revenue		$ 29,598.71
Expenses:		
Journal printing	$ 17,561.86	
Office salaries	5,515.00	
Journal postage	636.91	
Journal illustrations and engravings	55.47	
Journal envelopes	923.65	
Depreciation	261.82	
Clipping service	120.00	
Dues and subscriptions to other organizations and magazines	133.60	
Office supplies and expense	723.70	
Miscellaneous postage	722.08	
Auditing	95.00	
Total expenses		$ 26,749.09
Net profit		$ 2,849.62

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Treatment of Acute Hematogenous Osteomyelitis With Penicillin

W. A. ALTEMEIER, M.D.

CHEMOTHERAPY with penicillin has greatly modified the management of acute hematogenous osteomyelitis and altered the interpretation of the roentgenographic changes occurring in this disease.[1, 2] In the past, the results of treatment have been unsatisfactory for several reasons. Difficulties in diagnosis of the disease often resulted in delay and spread of the process with extensive destruction of bone. When early diagnosis was made, the principal method of arrest and control of the necrotizing process was emergency decompression of the involved area by surgical drainage followed by prolonged periods of immobilization. More recently, chemotherapy with the sulfonamides used as a supplement to surgical intervention aided in the control of the infection, but left much to be desired. Although the acute infection usually subsided and became greatly attenuated in time, a chronic suppurative process often followed, characterized by intermittently draining sinuses, sequestration, recurrent acute exacerbations, soft tissue abscesses, or bone abscesses either local or metastatic. Removal of the chronically infected bone by sequestrectomy or saucerization was usually followed by healing, but too frequently the disease appeared to be cured only to recur after an interval of many years.

THE DRUG MEETS THE NEED

The development of a potent and non-toxic chemotherapeutic agent effective in this infection was therefore greatly needed. Penicillin seems to have fulfilled this need.[1, 2]

During the past 31 months, we have studied 52 cases of acute osteomyelitis treated with penicillin. Included in the group were 44 cases of acute hematogenous osteomyelitis with involvement of the major long bones, with or without associated involvement of the flat bones of the pelvis, and 4 cases with hematogenous infection of the pelvic bones only. The responsible infectious agent was determined in all but four instances and was found to be the hemolytic Staphylococcus aureus in 42, the non-hemolytic Staphylococcus albus in 3, the Streptococcus hemolyticus in 1, and the Pneumococcus type III in 1.

The effectiveness of pencillin in acute hematogenous osteomyelitis depended largely upon the time of diagnosis and the onset of its administration, as well as upon the severity of infection. The best clinical results were ob-

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From the Department of Surgery, University of Cincinnati. The work described in this paper was done under a contract recommended by the Committee on Medical Research between the Office of Scientific Research and Development and the University of Cincinnati. Submitted on request, December 10, 1945.

tained in those cases diagnosed and treated early and conversely, poorer results in those diagnosed and treated late.

PLAN OF TREATMENT

The following plan of treatment, formulated for the control of the general and local manifestations of the infection, is recommended for the management of this disease.

1. Establishment of the diagnosis at the earliest possible time. Acute hematogenous osteomyelitis must be recognized on the basis of its clinical signs and symptoms alone, without help from the X-ray at the time when penicillin therapy can be expected to give the most brilliant results. One must, therefore, be thoroughly familiar with its clinical picture as well as its differential diagnosis. Some of the conditions that have been confused with acute hematogenous osteomyelitis include acute rheumatic fever, acute arthritis, scurvy, poliomyelitis, cellulitis, erysipelas, lymphangitis, and pneumonia. If there is any doubt as to the presence of acute hematogenous osteomyelitis, it is recommended that adequate penicillin therapy be started and continued until a definite diagnosis is made.

2. Early and adequate penicillin therapy. As soon as the diagnosis is made, a dose of 15,000 to 25,000 units of penicillin should be given intramuscularly or intravenously, and repeated every 2 or 3 hours for 4 to 6 or more days until the signs of infection are well under control. Thereafter and at the same intervals, the dose may be reduced to 10,000-15,000 units. A total dose of at least 1,500,000 units administered over a period of 2½, 3, or more weeks, seems to be adequate in most instances. The penicillin may be given by continuous intravenous drip as an alternate method.

3. Treatment of abscesses. Although emergency surgical decompression of the infected bones has been unnecessary in the great majority of instances, large soft tissue abscesses present at the start of treatment, or developing during treatment, should be incised and drained early. The necrotizing toxins and other toxic materials contained in the pus are thereby released, lessening the toxemia and further local necrosis. Small abscesses may be treated by repeated instillations at daily intervals of a solution of penicillin in physiological saline containing 5,000 units per cc. after aspiration of their contents with syringe and needle. If this course is followed, the involved area must be watched carefully to make sure the process is subsiding.

4. Immobilization of the extremity. During the acute phase of the infection, immobilization of the involved area is recommended for 2 to 3 weeks, preferably by a plaster splint or bivalved cast to permit inspections of the involved area. The progression or regression of signs of local infection may be observed directly and followed with this method. More experience is necessary to determine the advantages or disadvantages of further and prolonged casting. Arbitrarily, we have not permitted any weight bearing for at least three months in the cases showing the best response to therapy and longer as indicated in cases diagnosed and treated later in the disease. Immobilization by cast was used in approximately half of the cases for contrast with those treated without immobilization.

5. Adequate supportive therapy. Adequate supportive therapy with administration of small blood transfusions, fluids, electrolytes, and oxygen is indicated to overcome the effects of the infection and to restore the altered physiology to a normal level.

6. Continued vigilance. Vigilance is necessary to determine the progress and extent of the disease as well as to detect the development of soft tissue abscesses, metastatic visceral complications, purulent arthritis of contiguous joints, etc. If no significant drop in temperature occurs within 72 hours, we have learned to suspect the presence of infectious complications. The treatment of any of these complications must be determined on the basis of its own characteristics. If the signs of infection begin to subside, further conservative therapy is indicated. If, on the other hand, the infection should become fulminating, emergency surgical drainage must be instituted at the earliest possible time.

7. Serial roentgenographic examinations. It is recommended that serial roentgenographic examinations be made at intervals of one week during the early stages of disease and of one month during the later stages for at least one year, to determine the extent and nature of damage to the bone, the development of sequestra, involvement of adjacent joints, etc. A conservative attitude is recommended for the management of sequestra until it has been determined that spontaneous absorption or separation will not occur and until the most opportune time has arrived for their removal.

RESULTS

Under the therapy outlined, all of the 52 cases recovered but one of severe and neglected acute hematogenous osteomyelitis of the tibia with Staphylococcal pneumonia and bacteremia which was admitted to the hospital in a moribund condition and died 17 hours later. The mortality rate was therefore remarkably low, being only 1.9 per cent. There was also a striking reduction of the period of morbidity, particularly in those cases diagnosed early and treated adequately with penicillin.

It is difficult to assess the value of a chemotherapeutic agent in a disease such as acute hematogenous osteomyelitis with both generalized and localized manifestations of infection

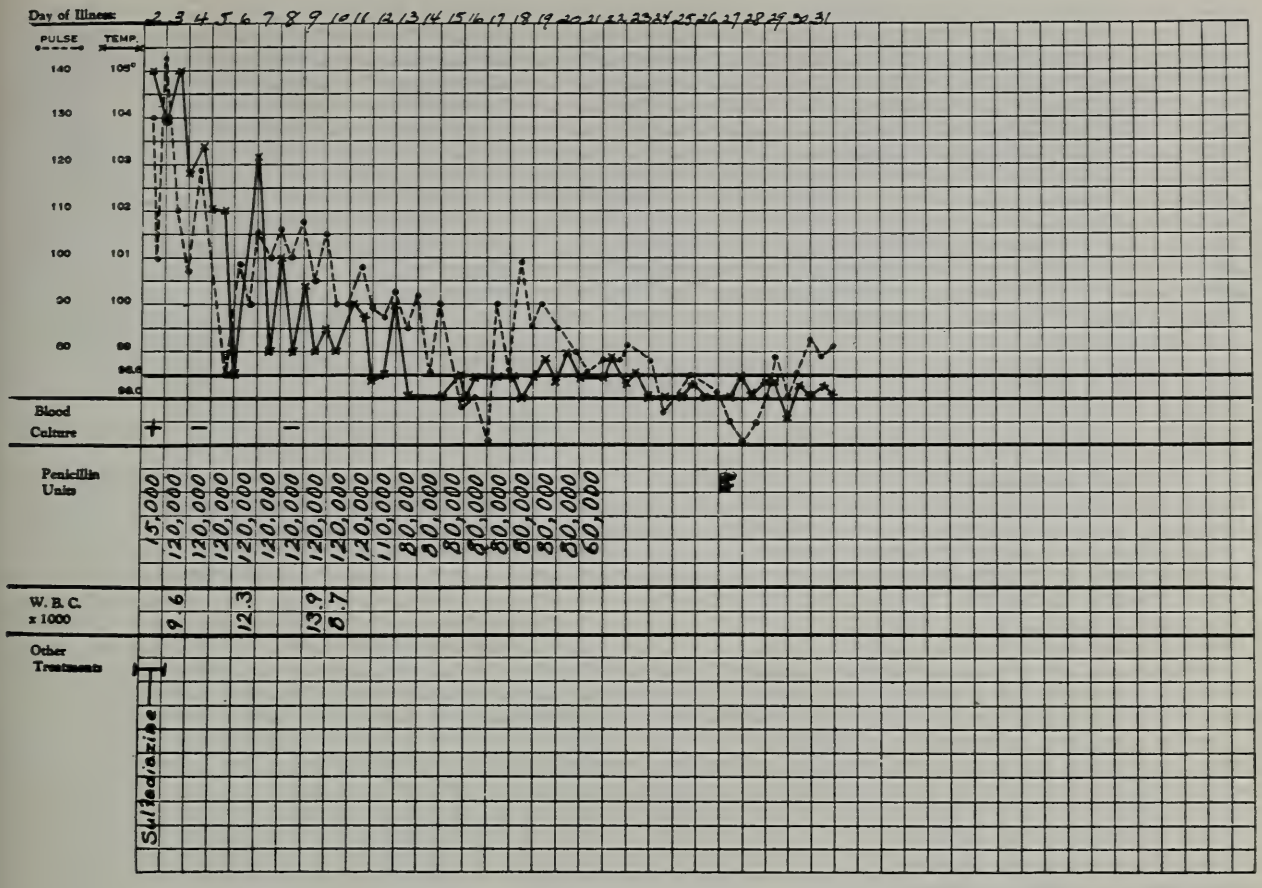


Fig. I. Case 41. Showing the results of penicillin treatment in an early case of acute hematogenous osteomyelitis of the right tibia with hemolytic Staphylococcus aureus bactermia.

and to determine accurately the result obtained in each case. In some instances of severe advanced hematogenous osteomyeltis with bacteremia, penicillin therapy sterilized the blood stream, saved the patient's life, and arrested the local infection, yet the disease had already produced extensive bone necrosis. The general result obtained in such cases might be considered excellent or good, but the severe local destruction of bone produced by the infection, principally before the start of treatment with penicillin, does not wholly justify this.

In general, the results of penicillin therapy, varying primarily with the time of diagnosis and start of treatment, fell into 4 groups:

GROUP I

If the correct diagnosis was made early, within the first 2 or 3 days, and adequate treatment was started immediately, the results were truly excellent. After a latent period of approximately 36 to 72 hours the fever, rapid pulse, bacteremia, toxemia, and other general signs of the severe infection began to disappear. By the end of 5 to 7 days, the temperature and pulse were usually normal, and the patient looked and felt quite well. Likewise, the local signs of infection such as tenderness, oedema, and redness also began to recede after a similar latent period of 36 or more hours. In this group immobilization by means of a plaster cast seemed to be of comparatively little importance, and there was an early return of function. Occasionally, it was practically impossible to keep some of the children off of the involved extremities as early as 2 or 3 weeks after the start of treatment. Surgical intervention was unnecessary in this group unless an abscess formed.

The roentgenographic changes which developed later in the involved bones were minimal, consisting of areas of localized periosteal reaction, small areas of patchy decalcification of the underlying cortex and metaphysis, little or no evidence of sequestration, and ultimate reconstitution of the bone. In some instances, these were hard to see and occasionally were temporarily overlooked. An additional 3 cases having typical symptoms and signs of acute hematogenous osteomyelitis were not included in the report since it was impossible to prove the diagnosis in the absence of positive roentgenographic findings. The following case report illustrates the excellent result of adequate penicillin therapy in an early case of acute hematogenous osteomyelitis with hemolytic Staphylococcal bacteremia.

Case 41. J. A., a 11 year old white boy, was admitted to the hospital in 11-12-44. Four days prior to admission he had developed a furuncle on his left elbow. Hot applications were applied by his mother and 24 hours later the lesion was

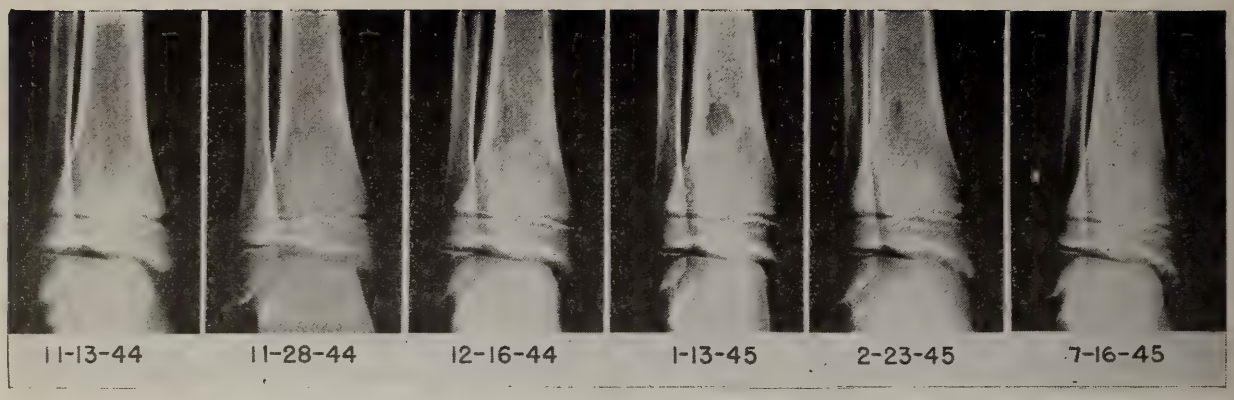


Fig. II. Showing bony changes occurring in Case 41.

11-13-44. No demonstrable bone involvement or periosteal reaction.

11-28-44. Very early periosteal reaction on medical aspect of the lower tibia and bone rarefaction in lower end of tibia.

12-16-44. Layering of the periosteum on medial aspect of tibia and extremely early elevation of periosteum on lateral aspect. Rarefaction in shaft of tibia has localized at a point about 5 cm. above epiphysis.

1-13-45. The periosteal reaction is much the same. The localized area of destruction is beginning to close.

2-23-45. There is some calcification of the periosteum, particularly on the medial aspect. Further healing is noted in the localized area of destruction in the shaft.

7-16-45. Recalcification and reconstitution of involved area is complete. No evidence of active infection.

incised and drained by his family physician. Shortly after this, he complained of pain in the left knee with inability to extend that leg. Hot applications and sulfonamide therapy were prescribed by his physician. Twenty-four hours before admission, severe pain developed in the lower third of the right leg which was followed by local redness and swelling, a persistent headache, high fever, and vomiting.

Examination showed a well-developed and nourished boy who was acutely ill. Over the left elbow a furuncle was present. No petechiae were visible. Examination of the chest and abdomen was essentially normal. Over the lateral and medial aspects of the lower end of the right leg, a swelling was present associated with increased heat and redness. This area was extremely tender to palpation and digital tapping of the upper portion of the tibia produced pain referred to the involved area.

The white blood count was 6,500 with 89 per cent polymorphonuclear leukocytes. Urinalysis showed the presence of 4+ acetone but no sugar or albumen. Blood cultures taken on the day of admission were positive for hemolytic Staphylococcus aureus. Roentgenographic examinations of the right tibia were negative at this time.

A diagnosis of acute hematogenous osteomyelitis of the right tibia with Staphylococcus aureus bacteremia was made. Penicillin therapy was started on the day of admission, giving 15,000 units every 3 hours for 10 days and 10,000 units every 3 hours thereafter for 8¾ days. A total of 1,745,000 units was administered. The patient's condition began to improve very definitely 36 hours after the onset of penicillin therapy (Fig. I). Temperature and pulse rates fell and his general condition appeared much better. The local signs of inflammation began to subside in the leg over the right lower tibia. These signs progressively decreased and after the 11th day, the temperature remained normal.

For purposes of study, no casting or other form of immobilization was used in this case. It is interesting to note that he was running about the ward without permission on the 14th day after his admission to the hospital. From that time on it was very difficult to keep him off his feet. He was returned home and has been under the care of his family physician. Progress and serial roentgenograms have shown periosteal reaction over the lower third of the tibia and gradual demineralization of an area in the metaphysis (Fig. II), followed by complete recalcification and healing of the involved areas.

GROUP II

When the diagnosis and treatment with penicillin were moderately delayed for 4 to 6 or 7 days, the general and local signs of infection were brought under control less promptly after a period of 2, 3, or more days during which little or no clinical response was evident. In this group local soft tissue abscesses developed more frequently. When small, they were treated successfully by aspiration of their contents and local injections of a solution containing 5,000 units of penicillin per cc. at intervals of 2 or more days. If large, they were treated with surgical drainage by incision to liberate the accumulated necrotizing bacterial toxins and to minimize further tissue destruction. The fall in temperature occurring after drainage was usually prompt and not delayed for 36 or more hours as in the cases treated with surgical drainage.

The roentgenographic changes developing in those cases were of great interest. Usually none was visible on the roentgenograms at the beginning of treatment. After a week or more had elapsed, periosteal reaction and localized patchy demineralization of the underlying bone became evident and increased progressively in extent and degree, becoming most marked 1 to 5 months after the onset of the infection. Recalcification of the demineralized areas followed with reestablishment of a normal or nearly normal appearance of the bone. Sequestration occasionally occurred in this group.

Case 3. J. C., a 13 month old white male infant, was admitted to the hospital on 10-23-43 with a history of fever associated with redness, swelling, and marked pain of the entire left

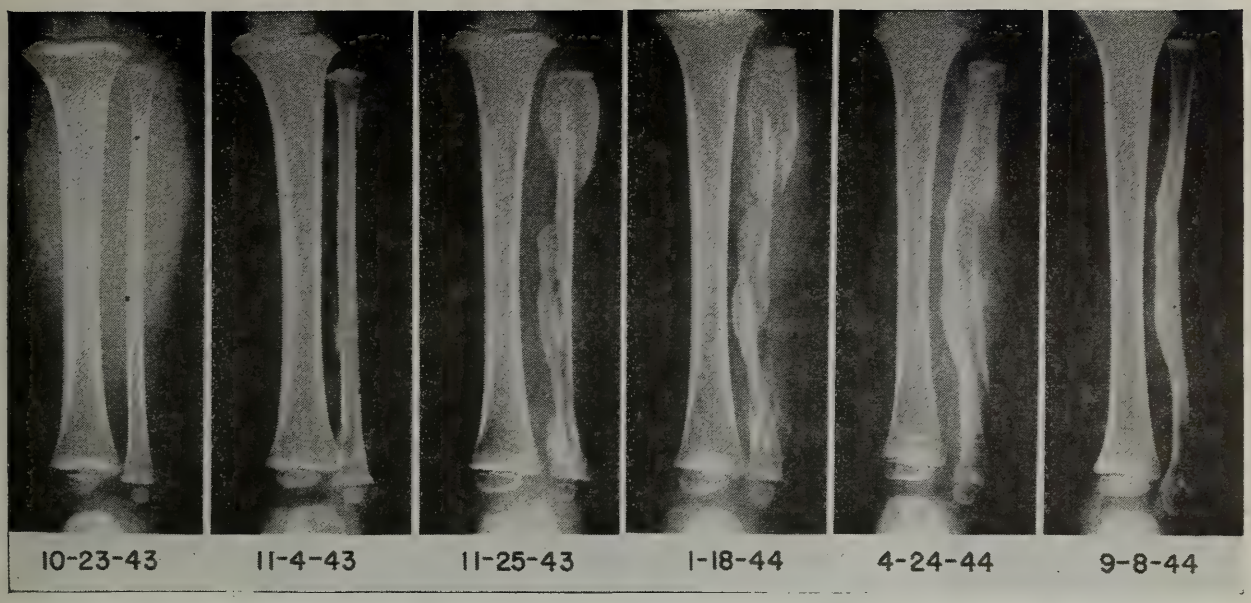


Fig. III. Showing the bony changes occurring in Case 3.

10-23-43. No definite X-ray findings in bone or periosteum.

11 -4-43. Rarefaction at proximate and distal ends of fibula with associated periosteal reaction. Also an area of periosteal reaction at level of junction of middle and lower thirds.

11-25-42. Bone destruction involving lower two-thirds of fibula. Absorption of proximal end. Marked perioteal reaction in these areas. Practically two-thirds of shaft is sequestrating.

1-18-44. Reconstruction has taken place in major portion of the fibula. The sequestrum is absorbing. Slight increase in the degree of periosteal reaction at proximal end.

4-24-44. Almost entire shaft has become recanalized. Long narrow sequestrum remains on outer portion of fibula in its middle third.

9 -8-44. Entire fibula has been reconstructed. Remainder of sequestrum not absorbed has been removed.

lower leg of more than 4 days' duration. He had been given sulfathiazole without obvious clinical improvement during the 3 days prior to admission.

At the time of admission there was marked oedema, redness, tenderness over the external malleolus, shaft of the fibula, and lower end of the tibia. The temperature was 102°F. and the white blood count was 32,000 cells per cubic millimeter. Urinalysis was essentially negative except for the presence of acetone. Blood cultures were negative. Roentgenograms showed no evidence of osteomyelitis. A clinical diagnosis of acute hematogenous osteomyelitis of the fibula was made. He was treated conservatively by immobilization of the extremity and administration of penicillin giving 15,000 units and later 10,000 units every 3 hours intravenously and intramuscularly. No surgical drainage was carried out.

The cast was bivalved 8 days after the onset of symptoms and a small subperiosteal abscess was aspirated yielding 12 cc. of thick gray pus containing Staphylococci. The cast was reapplied and the patient continued to receive penicillin and general supportive therapy. On the 5th day after the start of penicillin therapy, the temperature began to fall, reaching normal 6 days later. The patient was discharged to his home with no external signs of active inflammation present in the leg. No drainage sinuses or residual oedema were apparent.

Progress roentgenograms taken at intervals during the 11 months after onset of disease are illustrated in Fig. III. On 11-25-43, 1 month after admission to the hospital and approximately 2 weeks after completion of the penicillin therapy, considerable involvement of the proximal and distal ends of the fibula had developed with periosteal reaction involving most of the shaft and sequestration of practically two-thirds of the fibular shaft. Approximately 3 months after admission on 1-18-44, the periosteal reaction was increased in amount and was forming a new bony shaft for the fibula. The sequestrum of the old shaft of the fibula had been partially and spontaneously absorbed.

After this, the child was moved to another state and contact maintained through his orthopedic surgeon. Shortly after moving, he developed 2 small draining sinuses in the lower part of the affected leg and the roentgenograms on 4-29-44 showed that a long narrow sequestrum had become detached and was working its way to the surface. During a subsequent change in plaster casts, the sequestrum was found to be partially extruded from one of the sinuses and was therefore removed. Approximately 11 months after the onset of the disease, the roentgenograms showed reconstruction of the entire fibula with apparently complete healing. There has been no disturbance of growth of this leg, no deformity, and no impairments of function of adjacent joints. In June, 1945, the child was reported to be without complaints or signs of recurrence of infection.

GROUP III

If the diagnosis and treatment were delayed 7 to 10 or more days, and particularly if the infection was unusually severe, the local destruction of bone became very great and the formation of abscesses in the soft tissues and sequestra occurred in most but not all of the cases. Sequestration, however, was usually of limited extent and in some instances the sequestrum even seemed to act as an autogenous

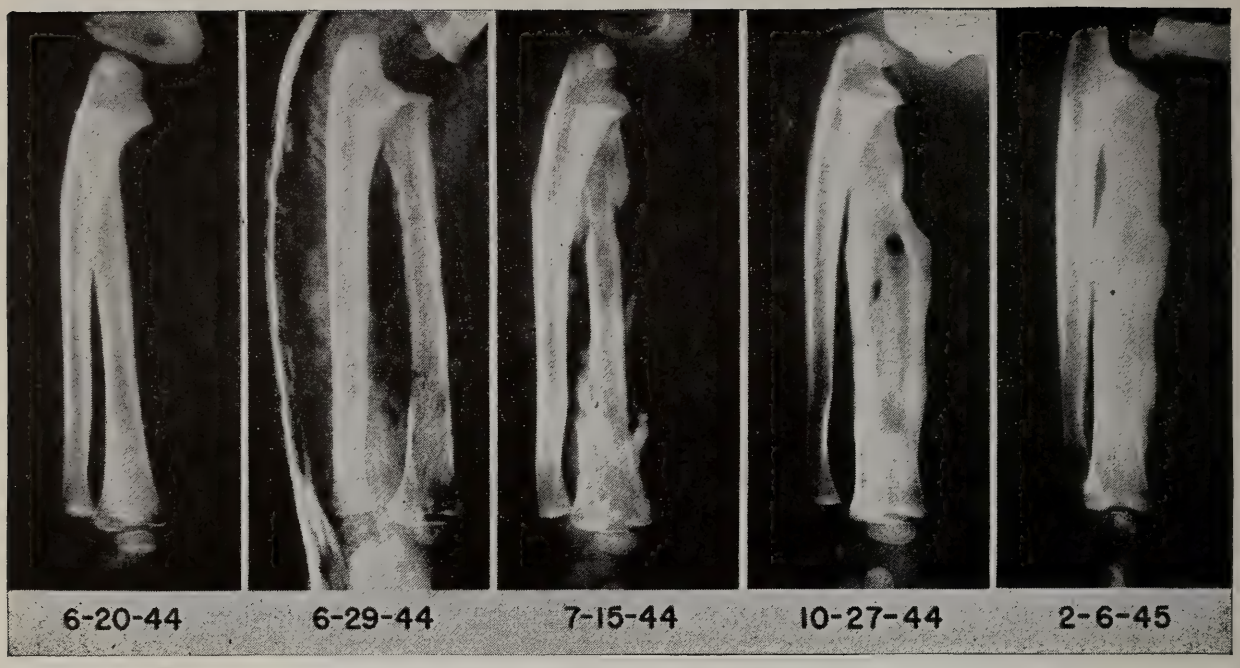


Fig. IV. Showing bony changes occurring in Case 22.

6-20-44. Rarefaction at distal end of radius, most likely early osteomyelitis.

6-29-44. Rarefaction has extended upward through distal half of radium and also involves the proximal one-fourth. Several breaks in the cortex. Periosteal reaction present, especially proximal end.

7-15-44. Very extensive periosteal reaction with absorption of both ends of the shaft and beginning sequestration of the middle third.

10-27-44. Extensive healing and reconstruction of the radius. The sequestrum representing the middle third of the radial shaft apparently has become revitalized.

2 -6-45. Practically complete reconstruction of the radius.

bone graft, participating in the reconstruction of the involved bone.

The local infection was arrested with more difficulty in this type of case and longer periods of treatment with penicillin were usually required. Small abscesses were treated by aspiration and large ones by incision and drainage.

The bony changes as revealed by roentgenograms showed extensive bone destruction at the start of penicillin treatment, which increased on subsequent examinations. Sequestration occurred in some instances. Small sequestra were absorbed spontaneously in some cases, and the fate of the larger ones is as yet undetermined. In Case 3, the sequestrum was partially absorbed and partially discharged spontaneously while in Case 22, the large sequestrum of the radius is still undisturbed. In contrast to the excellent result obtained in Case 41 which was diagnosed and treated early, the following report illustrates the limitations of penicillin in acute hematogenous osteomyelitis when diagnosis and treatment were late.

Case 22. R. J., a 3 year old negro boy, was admitted to the Cincinnati General Hospital on 6-14-44 with a chief complaint of swelling throughout the right forearm. Two days earlier he had cut his right palm and at that time it was noted that he also had a furuncle on his scalp.

He appeared acutely ill and his temperature was 104.6°F. There was a healing laceration of the left thenar eminence. Extending from the left wrist to the shoulder was a warm, exquisitely tender swelling which was greatest throughout the forearm.

The white blood count was 21,000 cells per cubic millimeter and the urinalysis showed the presence of acetone. Blood cultures were reported as negative on admission as well as on repeated subsequent examinations. Roentgenograms on his 6th hospital day showed small areas of demineralization and periosteal reaction about the distal end of the radius, but these were overlooked.

A diagnosis of acute cellulitis of the forearm secondary to an infected laceration of the hand was made. Sulfadiazine was started, 7½ grains being given every 4 hours. Massive wet compresses were applied to the arm. After 20 days on sulfadiazine therapy he continued to have daily elevations of temperature to approximately 100° F. and the appearance of the arm did not change appreciably. The bony changes as revealed by the roentgenogram had progressed markedly. Rarefaction of the distal half and proximal fourth of the radius with periosteal reaction was obvious, and several breaks in the cortex became visible, making the diagnosis of acute osteomyelitis of the radius apparent.

On the 23rd hospital day, we were asked to see the patient and penicillin therapy was started, giving 10,000 units intramuscularly every 3 hours. Sulfadiazine was discontinued. The arm was immobilized in a long arm cast. After 5 days the dose was reduced to 5,000 units every 3 hours. The course was one of slow improvement. The roentgenogram taken on 7-15-44 showed more extensive periosteal reaction with absorption of both ends of the radial shaft and beginning sequestration (Fig. IV). On 7-20-44, after 14 days of penicillin therapy, aspiration of the

forearm yielded a few cc. of fluid from which hemolytic Staphylococcus aureus, Staphylococcus albus, and a Streptococcus were cultured.

He was discharged on his 56th hospital day greatly improved. When seen in the clinic on 8-28-44, there was still some swelling of the forearm with a palpable irregularity along the surface of the radius. Progress roentgenograms taken on 10-27-44, 137 days after the onset of illness, showed that the periosteal reaction had thrown up an enveloping bridge of new bone about the sequestrum representing the old radial shaft. Of particular note was the apparent revitalization of the sequestrum similar to that seen in autogenous bone grafts. Further observation in this case has shown that some infection is still present. He was re-admitted to the hospital on 9-24-45 with a subacute abscess of the forearm of two weeks duration. Roentgenograms at that time showed no significant change, except the presence of a small sequestrum in the anterior surface of the forearm. Incision and drainage of the abscess was carried out under ether anaesthesia and 50 cc. of thick, yellow pus was obtained. Culture of the pus showed the presence of hemolytic Staphylococcus aureus. He was again discharged from the hospital on 10-27-45 and has since been followed in surgical clinic. He was last seen on 11-2-45, when the previous incisional wound had healed, with exception of two small granulating areas. Further observation will be necessary in this case.

GROUP IV

In certain fulminating infections in which it is apparent that the patient will not live the 48 hours or more necessary to obtain the maximum effect of penicillin, surgical intervention is still imperative as an emergency measure after adequate preoperative preparation. Penicillin therapy, continued postoperatively, aids greatly in the control of the infection.

DISCUSSION

Since the principal bacterial causes of acute hematogenous osteomyelitis, the hemolytic Staphylococcus, the hemolytic Streptococcus, the nonhemolytic Streptococcus and the Pneumococcus, are sensitive to the action of penicillin, it is not surprising that this penicillin has had such a profound effect upon the disease in its early stages before extensive thrombosis or stripping of the nutrient vessels to the involved bone occurred. Sterilization of the blood stream and control of the generalized infection reduced the mortality rate and the incidence of metastatic or secondary infection complications. On the other hand, penicillin almost certainly would be ineffective in osteomyelitis caused by gram negative bacilli. In the past, the mortality rate in acute hematogenous osteomyelitis has been approximately 25.0 per cent being 10-15 per cent in the milder cases and 50 per cent or higher in the septicemic types. The rate of 1.9 per cent in our series represents a significant reduction which we believe can be attributed largely to the effect of penicillin. If metastatic complications, such as staphylococcal pneumonis, pleuritis, pericarditis, thrombophlebitis, etc., already exist, penicillin is a powerful chemotherapeutic agent which aids in their control as an adjunct to surgical or conservative treatment as indicated in the individual case. Thus morbidity is also decreased.

LOCALIZED INFECTION

The localized infection is also brought under control and the roentgenographic changes in bone occurring in acute hematogenous osteomyelitis treated with penicillin are of particular interest. Early in the disease, during the first 4 to 10 or more days, the roentgenograms are of no practical value in detecting the nature of the disease. This emphasizes the fact that the diagnosis of acute osteomyelitis is purely a clinical one at the time when early and adequate treatment with penicillin will minimize or prevent damage of the bone. In many instances, penicillin therapy had sterilized the blood stream and had brought the generalized and localized manifestations of infection under control before any evidence of bone damage became obvious.

Later in the disease, usually after the cessation of chemotherapy, a succession of roentgenographic changes occurred. These changes varied with the age of the patient, the severity and duration of infection before treatment with penicillin, the adequacy of therapy, and the type of infecting bacteria. Periosteal reaction, patchy areas of demineralization and rarefaction of the involved bone and breaks in the adjacent cortex were early signs which usually became evident 10 to 14 days after the onset of the illness.[2] The findings increasing in extent and degree reached a maximum 1 to 5 months after the onset of the infection, and were invariably interpreted by the roentgenologist as representative of "an extension of the osteomyelitic process". We have learned to interpret the areas of rarefaction and breaks in the cortex of the involved bone as a measure of spontaneous absorption of the bone destroyed earlier in the course of the infection rather than a measure of an extension of the osteomyelitic process. The process suggests that adequate penicillin therapy arrests and controls the infection and may convert an area of septic necrosis of bone to one of aseptic necrosis.

ABSORPTION

The spontaneous absorption of the dead bone is followed by recalcification of the involved area often with re-establishment of normal or near normal bony architecture. Reconstitution of the bone seemed to occur with less resultant bone sclerosis than that seen by other previous forms of treatment.

Although sequestration was relatively uncommon in the cases treated with penicillin, it still occurred late in the illness if the infection was unusually severe, if the diagnosis was delayed or

if the treatment was late or inadequate. When it did occur, it was usually followed by spontaneous absorption of the smaller pieces, partial absorption of the larger ones, spontaneous extrusion of detached larger sequestra in some instances, or by recanalization and organization of large sequestra similar to autogenous bone grafts. In at least two of the cases, sequestrectomy apparently will be necessary at a later date.

It is important to realize that no obvious clinical improvement may be apparent for a period of 48 to 72 or more hours after the onset of penicillin therapy in the patients treated without surgery. This is a very trying period during which considerable pressure may be brought to bear upon the surgeon by the pediatricians, internists, or other surgical consultants in favor of immediate surgical intervention.

In some instances, surgeons unfamiliar with the action of penicillin were unwilling to complete the conservative treatment and performed local surgical drainage when we believed it was unnecessary. Very close observation is required and a decision to operate may become necessary if the infection becomes so severe that the patient will not survive the 48 or more hours necessary for full penicillin effect. In the majority of instances, however, complicating or metastatic infections should be looked for if a sharp fall in temperature and marked clinical improvement do not occur at the end of this latent period. Later in the course of the disease when the roentgenological appearance of the bone became so "bad", it again became difficult to withhold surgery in face of reports that extension of the destructive chronic osteomyelitic process has occurred.

A PROGRESS REPORT

Although this is only a progress report, there seems to be little doubt that adequate penicillin therapy can eliminate the necessity of emergency surgical intervention in the majority of early cases of acute hematogenous osteomyelitis. In the past there has usually occurred a considerable degree of secondary contamination of areas of osteomyelitis treated by surgical drainage. Devitalized tissue exposed to the air invites mixed or saprophytic infection particularly by various gram negative bacilli, and it is often difficult to prevent this type of secondary infection. Secondary invaders have frequently been resistant to penicillin or even destructive to penicillin.[3] The elimination of this complication by penicillin therapy without surgery may be a very important factor in the arrest of the local infective process and the spontaneous absorption of devitalized bone.

Since the local process in the bone is essentially one of diffusing infection characterized by purulent exudation, thrombosis of adjacent blood vessels, and necrosis, the death of bone may become extensive if the infection is unrecognized or unchecked. In penicillin there is now available a chemotherapeutic agent which can check the infection and even permit spontaneous resolution of the osteomyelitic process. It is apparent, therefore, that early diagnosis and early intensive penicillin therapy are extremely important if the destruction of bone is to be minimized. It must be emphasized that early diagnosis can only be made on clinical grounds and little or no help is to be expected from the roentgenograms for 10 or more days. If there is any doubt as to the presence of an acute osteomyelitis, it is better to start penicillin therapy rather than wait until the diagnosis is proven.

SUMMARY

A study during the past 31 months of 52 cases of acute hematogenous osteomyelitis indicates that penicillin is a powerful and effective chemotherapeutic agent in this disease. Penicillin has not only radically changed our ideas concerning the most satisfactory method of management, but has also altered our interpretation of the significance of some of the roentgenographic changes occurring during the course of the disease. When administered early and adequately, it reduces mortality and morbidity, controls the infection, minimizes local destruction of bone and resultant deformities, permits spontaneous absorption of necrosed bone and healing, and allows earlier return of normal or nearly normal function.

BIBLIOGRAPHY

1. Altemeier, W. A., and Helmsworth, J. A.: Penicillin Therapy in Acute Osteomyelitis. Surg., Gyn. and Obst., 81:138-157, Aug., 1945.
2. Altemeier, W. A., and Reinecke, H. G.: X-Ray Interpretation of Acute Hematogenous Osteomyelitis Treated with Penicillin. The American Journal of Roentgenology and Radium Therapy, 54:437, 448, Nov., 1945.
3. Altemeier, W. A.: Inactivation of Penicillin by Various Gram Negative Bacteria. Surg., Gyn. and Obst., 81:379-383, Oct., 1945.

Most of our cases of active pulmonary tuberculosis in years to come will develop from the group of school children who are reactors to the tuberculin test today. It is important to stress that all such reactors should be carefully watched, X-rayed annually and, whenever possible the source of infection traced to prevent further spread of the disease. When an individual reacts to tuberculin, two important facts are immediately established: (1) the individual is at least a potential case of clinical tuberculosis; and (2) there has been a source of infection which may be sought among contacts. —Lewis S. Jordan, M.D., Journal-Lancet, April, 1945.

* * *

Tuberculosis is a social problem with a medical aspect. Sir William Osler.

What Lessons Have We Learned in Military Neuropsychiatry That Have Application for Civilian Life?

NICHOLAS MICHAEL, M.D.

SOMETHING good does come from evil. This war has given neuropsychiatry an opportunity to show what it can accomplish for the prevention and treatment of psychiatric casualties.

The rejection of large numbers at the Induction Station and the discharge from the service of individuals because of neuropsychiatric disorders revealed that the physical part alone does not make a good soldier. This forcibly called our attention to the fact that a group of people are constitutionally poorly equipped to meet not only the ordinary demands of military training, but also the everyday issues of life. It was contrary to the former belief which was in force prior to the war that a physical examination was all that was necessary for acceptance in the Armed Forces.

The medical profession as a whole knew of but ignored or avoided this group and, excluding the efforts of a comparatively small number of psychiatrists, did nothing as far as prevention and treatment were concerned. The neglect of neuropsychiatry in our medical education became apparent when medical officers frequently failed to recognize obvious neuropsychiatric disorders. They assumed such condition existed after repeated physical examinations (process of elimination) failed to reveal evidence of organic pathology. This of course resulted in prolonged hospitalization, unnecessary expenditures and loss of time. The neuropsychiatric disorder became fixed, chronic, and difficult to treat.

PATIENT A PERSON

The successful medical officer discovered that his patient was an individual frequently influenced by his incapacity and environment. As busy as he may have been he knew the value of sitting down for a few minutes and talking things over. In this way he not only showed interest in the wound but in the patient's welfare and comfort. He found that his patient frequently had a co-existing functional disorder. A visible bullet wound did not eliminate entirely the possibility of an anxiety, conversion, or other psychiatric reaction. He was able to solve with or without the aid of the neuropsychiatrist some minor problems which in themselves were not serious, but frequently had the tendency to disturb or upset the patient. Failure to recognize the individual as a whole resulted in low morale and infraction of the rules. Dsciplinary measures and punishment alone resulted in a more aggressive and non-cooperative patient.

Severe stress for a prolonged period of time frequently produced symptoms of a psychoneurotic or a psychotic disorder in an otherwise stable individual. Depending on his personality make-up, every man had his breaking point. Indviduals with unstable, immature, neurotic personalities may temporarily have given a good account of themselves but could not stand as much stress as others. The strain of responsibility proved too much for some commissioned and non-commissioned officers. The death or injury of soldiers under their command sometimes produced guilt feelings and acute anxiety. Individuals who did not give a history of predisposition responded better to treatment and became symptom free.

Patients suffering even with severe psychoneuroses have been treated successfully and sent back to duty. When properly assigned they were capable of doing useful and necessary work, some of them more than the call of duty. Many of the best soldiers in fixed installations were neurotics. They were treated as ambulatory patients with a minimum loss of time from their duties. It was necessary to keep them encouraged and show them there was a need for their services. The product of their work alone increased their confidence and gave them more reassurance.

GENERAL HOSPITALS

Psychotic patients could be treated in General Hospitals. Separate hospitals were not necessary.

With modern methods of treatment, psychotic

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Submitted January 16, 1946.

reactions were reversible in the great majority of cases. The percentage of reversible reactions would have been higher if post-traumatic and psychosis of long standing were not included. With intensive treatment only about 10 per cent need be sent to Veterans Hospitals. Electric or insulin shock alone was not likely to sustain a remission. Intensive psychotherapy was essential and daily interviews with the psychiatrist were necessary. The patient was not permitted to remain idle on the ward for this frequently resulted in a relapse. He took an active part in occupational, educational, and recreational activities. Proper follow-up after their discharge was necessary.

The psychiatrist, psychologist, social worker, psychiatric nurse, occupational and recreational therapists and attendants constituted a necessary team. Each one had an important part in the treatment of the patient.

The above are some of the lessons we have learned in military neuropsychiatry none of which were new. They were advantageously applied to military life and can be applied to civilian life. We may implement these lessons so that they are applied in civilian life as follows:

The public in general does not understand what constitutes a neuropsychiatric disorder. Mental illness is no more of a stigma than physical illness. Reeducation along that line is necessary.

Establish more child guidance centers and neuropsychiatric clinics supported by the city, state or private endowment. It will be necessary to interest more doctors in psychiatry.

Medical schools must devote more time to neuropsychiatric disorders so that the doctor may more easily recognize the premonitory symptoms and refer the case to a psychiatrist for proper treatment.

FOLLOW UP

Follow-up clinics for veterans should be established in all fair size communities with the emphasis on treatment rather than on how much more or how much less pension a veteran should get. A pension is destructive and stifles ambition. The present set-up is totally inadequate. Instead of more beds there should be more qualified psychiatrists and efforts be made to treat veterans as outpatients rather than to be hospitalized. Social workers should visit veterans frequently, help them with minor problems and advise relatives who do not understand the nature of the illness.

General Hospitals should provide facilities for the care of psychiatric disorders. A wing or a floor may be set aside for such types of patients. This has been successfully accomplished in many cities.

The time of the large Veterans and State Hospitals is past. Instead of adding more new buildings or repairing the old, it would be better to establish small psychiatric regional hospitals in every part of each state. If we can devote as much time to the mentally ill as we do the physically ill, the results will be just as good. The need for additional doctors and other personnel to staff these hospitals will be apparent. Attraction of more doctors to this field will stimulate research, a necessary part in all branches of medicine.

Physicians should always treat the patient as a whole. They must look beyond the injured limb or diseased organ to see how the incapacity is influencing the personality make-up of the individual. As quoted from Plato:

> "That as you ought not to attempt to cure the eyes without the head or the head without the eyes so neither ought you to attempt to cure the body without the soul and this he said is the reason why the cure of many diseases is unknown to the physicians of Hellas because they are ignorant of the whole which ought to be studied also; for the part can never be well unless the whole is well. For this is the great error of our day in the treatment of the human body that the physicians separate the soul from the body."

BIBLIOGRAPHY

The Works of Plato, The Jowett Translation Tudor Publishing Co., The Dialogues of Plato, Vol. IV, Part I, Page 12.

Carcinoma of the Cervix

The problem of lowering the mortality rate of malignancy of the cervix (in fact to be exact one should say, "malignancy in general") rests upon the shoulders of the medical profession. This can be accomplished, first, by education of the public, which is being done with increasing fervor through the Field Army of the American Cancer Society. Second, by proper and thorough examination of the patient when she presents herself; supplemented in every instance where any suspicious tissue prevails by removal of some of the tissue for microscopic study. Third, by institution of proper and adequate therapeutic measures following a thorough study of the case. Each case should be individualized. Fourth, by building up the patient's resistance following the institution of therapeutic measures. Fifth, by a complete follow-up of the patient for a period of five years, or more if necessary.—J. William Hofmann, M.D., Indianapolis; Jr. of Ind. State Med. Assn., Vol. 39, No. 4, April, 1946.

Infantile Paralysis a Complication of Influenza

O. P. BIGELOW, M.D.

THE epidemiology of anterior poliomyelitis, hereafter called polio for brevity, has always been a puzzle. For instance, only one case may appear in a town, a county, or a city during a period of several months. It is certainly a germ disease; but how did the victim become infected; from whom; and why doesn't he pass it on to others? If there are several cases in a city at the same time, they are usually so isolated from one another that the same questions still apply. There have been many efforts to explain the spread of the disease by implicating insects and water supplies, but these explanations haven't been at all convincing.

I believe that polio is not a distinct disease, but a rare complication of a very common disease. This makes its oddities of distribution crystal clear, no harder to explain than the scattered cases of tabes dorsalis and tubercular meningitis. Really, can you think of any other explanation?

If polio is a complication, then what disease does it complicate? This could hardly be anything but influenza. They are both virus diseases. Polio starts like influenza; and, up to late years, it remained "influenza" unless paralysis appeared, when the diagnosis was changed to "infantile paralysis". Sometimes the paralysis is not apparent for some time, as when the muscles which help support the spine are affected. The resulting scoliosis may not be noticed for weeks or months. Then the history is given by the family that it followed "a hard case of flu". Thus, out of the mouths of babes cometh wisdom.

The influenza virus has a great affinity for nervous tissue. Almost every case shows some degree of neuralgia, neuritis, meningeal irritation or mental disturbance. Influenzal meningitis was recognized by our ancestors. Then why shouldn't the spinal cord be attacked at times as well as every other part of the nervous system? It would be more surprising if it never were. The preference of this virus for the anterior grey matter of the cord would be analagous to the preference of the syphilitic spirochete for the posterior columns.

"Polio epidemics" are easily explained. Different epidemics of influenza show a wide variation in the bodily structures attacked—lungs, bronchi, sinuses, intestines, peripheral nerves or central nervous system. And pathologists are already recognizing Types I, II, et cetera, of the influenza virus.

"Polio" is being diagnosed in many more cases than it used to be. Especially during epidemics, lumbar puncture is now performed on many patients who show no paralysis; and if the spinal fluid shows increased cells and protein, the case is labeled "polio". (This in spite of the fact that the cells and protein may come from any part of the central nervous system which is bathed by the spinal fluid.) In the excitement of the chase, other persons in the family who show the same clinical symptoms, but normal spinal fluid, are sometimes diagnosed polio also —"abortive polio". Patients with bulbar involvement and cerebral meningitis are also usually labeled polio during an epidemic.

I agree that all these people, and the ones with typical polio too, have the same infection. But I believe that it is by the influenza virus. Thus, a stricter quarantine of influenza would do more toward stopping a polio epidemic than dusting the town with insect powder from an airplane.

Submitted January 23, 1946.

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Transurethral Prostatic Resection on Elderly Patients

The mortality rate for all patients who undergo transurethral prostatic resection ranges from 1 to 2 per cent. For elderly patients the mortality rate is higher, but it is not more than 2 or 3 per cent.

Complications occur most frequently among the elderly patients, who accordingly require more careful medical care.

Carcinoma of the prostate occurs more frequently as the age of the patient increases. At present the treatment of choice in cases of carcinoma of the prostate is transurethral resection and postoperative hormonal therapy. Bilateral orchectomy is reserved for a special group of patients.—Thomas L. Pool, M.D., Minneapolis; Geriatrics, Vol. 1, No. 2, March-April, 1946.

An Effective Drug in the Management of Cough and Hemoptysis in Pulmonary Tuberculosis

HAROLD G. CURTIS, M.D., and ROBERT H. BROWNING, M.D.

ONE of the most common symptoms in pulmonary tuberculosis which requires medication is cough. This is present in a great number of persons undergoing sanatorium treatment. Usually codeine or a preparation containing it is used for the relief of cough in this condition. A fairly common complicaton of tuberculosis which also requires the use of opiates is pulmonary hemorrhage. Here also codeine, and sometimes morphine, are used, in spite of their known drawbacks. They have had to be used for lack of a more satisfactory therapeutic agent.

This preliminary report deals with the use of dihydrocodeinone (available under the name of hycodan bitartrate, Endo Products, Inc.) in the management of these two conditions. In our experience it has frequently proved more effective than codeine for the control of cough, and superior to it in the management of pulmonary hemorrhage. To date, hycodan has been used in the control of cough in 42 cases for a sufficient period of time to permit an evaluation. It has been the sole opiate used in the management of 22 cases of pulmonary hemorrhage in tuberculosis.

THE DRUG

Dihydrocodeinone is quite closely related structurally to codeine. Its pharmacological properties are similar to those of codeine in some respects, and to morphine in others. G. N. Myers (Brit. Med. Jour. 2:283, 1933) studied its action in cats, principally with respect to its gastrointestinal and respiratory effects. He states that dihydrocodeinone in therapeutic doses is practically without effect on the cardiovascular system, and on the motility of the stomach and pyloric sphincter. It increases the tone of the ileocolic sphincter. The smooth muscle of the bronchioles is apparently not affected by the drug. The respiratory center was found to be depressed to a degree similar to that of dilaudid and morphine. Myers concluded from his experiments that dihydrocodeinone is in general intermediate in its actions between codeine and morphine.

Evaluation of the antitussive action of a drug by the use of laboratory animals is practically impossible. It is, therefore, necessary to depend on clinical observation to determine the effectiveness of a drug used for the control of cough. Several European investigators have reported satisfactory relief of cough from dihydrocodeinone, with a low incidence of side effects. These reports are summarized in the *Bulletin of the Health Organization of the League of Nations* (Vol. 8, p. 387, 1939).

The 42 cases in this series, who have received hycodan for a sufficient period of time to permit an evaluation of its effect on cough, consist of 3 with a diagnosis of minimal tuberculosis, 14 moderately advanced cases, and 25 far advanced. Five of the far advanced cases terminated fatally. There were 18 males and 24 females. The age distribution is as follows:

Age Range	Number of Cases
15-20	6
21-30	18
31-40	9
41-50	4
51-60	3
over 61	2

The period of time over which hycodan was used daily is shown below:

Duration	Number of Cases
less than 1 month	5
1-3 months	13
3-5 months	13
5-7 months	5
7-9 months	3
more than 9 months	3

The dosage used ranged from 1 tablet (5 mgm.) once daily to 2 tablets four times a day. Four

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From Sunny Acres Sanatorium, Cuyahoga County Tuberculosis Hospital, Cleveland, Ohio, and the Department of Medicine, Western Reserve University School of Medicine. Submitted November 13, 1945.

of the five patients listed as having received hycodan less than one month are cases newly admitted to the sanatorium. They are still receiving the drug as needed. Many of those who received hycodan for periods up to 5 months represent cases in whom clinical improvement has been such that cough is no longer a symptom.

There has been no special attempt in these cases to compare the efficacy of hycodan with that of other drugs for the relief of cough, in the nature of a controlled therapeutic trial. A rather large number of the cases are those of patients who had previously been on codeine and were changed to hycodan without being in any way informed of the change. The physical appearance of the tablets of hycodan and codeine is similar, so that there was no indication to the patient that a change in the type of medication had been made. Many of the observations recorded here were volunteered by the patients.

Hycodan is best given after meals, as it sometimes tends to cause nausea when given on an empty stomach. The last dose at night was preceded by some milk. These precautions were so effective that only one patient complained of nausea.

THE ACTION

The onset of action of hycodan is quite prompt, especially when it is considered that absorption is probably delayed by the presence of food in the stomach. Two patients volunteered the information that relief came on more quickly with hycodan than with codeine. The duration of effect of a single dose seems to be about four hours, and probably longer in some cases. In some cases two daily doses were adequate where three or four daily doses of codeine had been required.

Many patients indicated, and the nurses' and resident staff's observations confirmed, that relief from cough was more satisfactory with hycodan than with codeine. The frequency of coughing was reduced more by the hycodan, and the coughing which did take place was less irritating and severe.

The subjective relief from cough resulting from hycodan was apparently quite satisfactory in the majority of cases. It was noted fairly often that patients allowed more than four hours to elapse before requesting a second dose of hycodan; apparently the cough did not recur with sufficient frequency to be disturbing. This was in contrast to the situation frequently prevailing under codeine, where the patient was sometimes coughing appreciably often before the end of the four-hour period between doses. The tendency not to ask for a second dose of hycodan until it was absolutely needed seemed to indicate that the dose which was adequate to produce effective relief of cough did not produce any significant degree of euphoria.

In this series, there has been no evidence of the development of dependence, tolerance, or addiction, even in the five cases who have received over 500 doses of hycodan. In most cases, the initial dose of hycodan was one 5 mgm. tablet. Where this did not prove effective, it was promptly increased to two tablets. In no case has it been necessary to increase the initially effective dose at a later time. Even in the cases with fatal termination, reasonably adequate relief of cough was obtained with 10 mgm. doses until the approach of exitus required the use of morphine.

The incidence of side actions from hycodan was very low. Constipation, which is so very common from the use of codeine, was much diminished under hycodan. This is an important consideration in patients who tend to become constipated as a consequence of being confined to bed. In one case, nausea was noted; it was severe enough to require discontinuance of hycodan and a return to codeine.

There were 4 cases of patients formerly receiving codeine, in whom the substitution of hycodan did not prove satisfactory. One was the case mentioned above, in which hycodan produced nausea, and codeine did not. In two other cases, 5 mgm. of hycodan was less satisfactory than ½ grain of codeine. The effect of 10 mgm. doses of hycodan unfortunately was not studied in these two cases. The fourth case was one in whom 5 mgm. of hycodan was less satisfactory subjectively than ¼ grain of codeine. This patient had been receiving this dosage of codeine 2 to 4 times daily for almost two years; there is a possibility of dependence on the codeine which was not satisfied by hycodan. One other case failed to receive adequate cough relief from hycodan, but was not helped appreciably by codeine either.

PULMONARY HEMORRHAGE

On the basis of experience obtained with hycodan in the control of cough, it was felt worth while to institute its use in the management of pulmonary hemorrhage. The desiderata of treatment in this complication of tuberculosis are: That the patient be kept quiet, that cough be reduced to a minimum, but not abolished altogether, and that blood entering the bronchial tree be expelled promptly and completely. Furthermore, constipation with its attendant straining at stool should be avoided, so that the blood pressure be not raised by the extra effort to the point where hemorrhage again takes place.

Morphine and codeine have both been used for this condition, in spite of their obvious drawbacks. Morphine, in a dose which produces adequate sedation, may abolish the cough reflex rather

than merely depress it, so that blood will not be expelled, but retained within the bronchial tree, possibly to cause partial collapse and spread infection or, in extreme cases, to cause the patient to become asphyxiated. Codeine has the undesirable features of causing retention of sputum, which in this circumstance means retention of blood, and also of inducing constipation.

Since hycodan was found to give effective relief of cough without suppressing the cough reflex, and not to lead to appreciable retention of sputum and blood within the bronchial tree, or to constipation, its use as the sole opiate in the management of pulmonary hemorrhage was instituted. The dose of hycodan used routinely for this purpose was 5 mgm. every 4 hours. To obtain the necessary sedation, phenobarbital was used. This regimen has been used in 22 cases of pulmonary hemorrhage. The results obtained have been in accordance with the expectations based on the experience previously gained with the use of hycodan; it gave fairly effective relief of cough without apparently interfering with the raising of sputum or blood, and without causing constipation and the resultant straining at stool. The use of hycodan in the routine treatment of pulmonary hemorrhage is therefore being continued.

SUMMARY

Hycodan bitartrate has been used for a period of several months in the control of cough in 42 cases of pulmonary tuberculosis. It has been found to give effective relief of cough, and not to cause significant retention of sputum in therapeutically adequate dose. The incidence of undesirable side actions, particularly constipation, from its use is low. No evidence has been found thus far in this short series of cases, of either tolerance, dependence, or addiction to the drug.

In the treatment of pulmonary hemorrhage occurring in the course of tuberculosis, hycodan is being used routinely as the sole opiate. The results in 22 cases to date have been satisfactory, and hycodan promises to show superiority to codeine and morphine in the management of this complication.

Infant mortality is the only numerical measure available for health trends, but the brunt of deterioration in diet is borne by adolescent children, who are especially susceptible to tuberculosis. The average town child in Europe is underfed, short of vitamins and too hungry to concentrate. The father may be dead, a prisoner of war or a deportee, and the child may spend the day in search of food, too weak for exertion, without soap to keep clean. It is on this decimated enfeebled generation that the reconstruction of Europe will depend.—Foreign Letter, J.A.M.A., May, 1944.

KEEPING UP WITH MEDICINE

THERE is a decided lack of health consciousness which fails to seek the medical sources already available.

* * *

A RECENT survey of biologic false positive serologic tests for syphilis divided them into two major groups: (1) Those caused by respiratory and infectious diseases, and (2) those caused by immunizations such as smallpox and tetanus toxoid.

* * *

IMMEDIATE mortality of coronary artery disease increases with the advancing years. In other words the older you are when hit the shorter will be your time.

* * *

FROM every standpoint **vernal catarrh** appears to be on an allergic basis yet the specific sensitivity can rarely be proved.

* * *

NASAL allergies require prompt care for, if neglected, they are prone to develop into chronic sinusitis, bronchitis, or asthma.

* * *

ACUTE retention of the urine in infancy is most commonly due to closure of the external urinary meatus with precipitated phosphates.

* * *

THE endocrine aspect of impotence constitutes but a small part of the entire problem. In the majority of cases, psychic factors play the more important part.

* * *

THE restoration of autonomic functional imbalance in the treatment of allergic disease is of fundamental importance.

* * *

ANTIBODY-atopen reactions, which are closely related to the specific immune reactions, are regulated through the cholinergic nerves.

* * *

WHERE allergy plays a part in migraine, as it usually does, the atopen of the specific hypersensitivity is almost always a food.

* * *

THEY now tell us that coronary occlusion occurs in persons of a definite personality type. The usual story, they say, is that of a stubborn, self-willed child who entered early into competition with a much-feared and envied parent.

* * *

BORIC acid preparations are but weakly germicidal. Their use should be discouraged because of the very real danger of accidental poisoning.—J. F.

The Problem of Reconditioning and Rehabilitation as Related to Cardiac Diseases

ROBERT H. SCHOENE, M.D.

WHEN the final score sheet is tallied on the present world conflict many interesting, amazing, revolutionary, and mankind-benefiting facts will be recorded. One of the foremost will be the contribution of the Medical Corps as an entity towards the goal of not only devising new ways to save life and mind, but also new methods used in the restoration of these injured, diseased bodies and minds to their rightful place in society.

Among the most notable contributions the Medical Corps has made, has been its efforts in revising the older thoughts and trends towards convalescence and its institution of the reconditioning and rehabilitation of patients suffering from injury or disease, both mental and physical. This work has been widespread, most thoroughly carried on and indoctrinated into the Corps from the Commanding General down to the lowest buck private. We can all, I am sure, recall the early months of the "must" program. Many took part in it, feeling it was a necessary evil and a whim of the brass hats devised to plague an already overworked group of medical units and their staffs. I believe, however, that I can now safely say that the principles of reconditioning and rehabilitation of the patient have been sold 100 per cent to the part of the profession that has actively participated in World War II. I am also sure that many at home have, skeptically at first but now routinely, adopted these tenets as an integral part of their practice. We must fully realize that this program is primarily a medical problem but the doctor alone can not accomplish this mission; rather it requires the valuable help of many working together as a whole team, whether it be in the Army or in civilian life.

Let us define the terms in this discussion: Rehabilitation has several meanings according to Webster, but in an over-all summation we can best define it as the restoration of one to efficiency, enabling one to make his livelihood again. It pertains to mental and physical training or education designed to fit one for a useful productive place in society, self-reliant, properly motivated, and contributing his full capabilities to himself and his fellowmen. Reconditioning pertains to the state of being fit, more particularly physical but including mental and moral fitness. It bears no designation referring to motivating, training, or orienting the individual to a useful productive place in society.

Submitted February 15, 1946.

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This program was first a general one which before long became more or less specific, particularly after setting up definite centers for concentrating specific diseases and injuries. An example of this that we are all familiar with is the brilliant work that has been done in revising many of our older concepts of management in chest casualties, including their convalescence and reconditioning. It is our purpose today to discuss specifically the problem of convalescence, reconditioning, and rehabilitation in cardiac disease.

As a working rule, the sheet anchor of treatment in all cardiac diseases has been rest, and like all therapeutic procedures handed down by our predecessors we have adopted this "rule of rest", exploiting it still further in this type of case until it has become axiomatic. Until recently, no challenge to this concept has arisen from the medical profession. In recent years, however, the medical men in the Armed Firces and civilian life, aided by the impetus afforded by the necessity in conserving and salvaging manpower in the past 4 or 5 years have attacked this age-old view of absolute, prolonged bed rest in the management of cardiac cases. It has been noteworthy that the work has been well-grounded fundamentally, starting by studying the effect on normal individuals of prolonged and forced bed rest. We can sum up this primary work by stating that it has been proved that there is an increasing incapacity of the cardiovascular system to maintain circulation adequately under these conditions. This fact has also been shown and proved in many acute disease states. Much value has been accrued from these studies in

bringing patients back to better general health in a much shorter period of time.

Two fundamental commandments in the practice of medicine are:

1. "Be sure you do no harm".
2. "Thou shalt not generalize".

Generalization has no place in any discussion relating to medicine and its allied branches and our discussion is in no way to be taken in this manner. We would rather you would consider it as a pliable yardstick to be used in evaluating each case as an entity. One can consider many types of cardiac disease in this paper but time does not permit. We will consider Congestive Heart Failure, Acute Rheumatic Heart Disease, and Coronary Insufficiency. We will also discuss briefly the reconditioning and rehabilitation of those many cases who have been incorrectly diagnosed as cardiacs and who as a result have the fear of heart disease, or as we commonly state, cardiophobia.

CONGESTIVE HEART FAILURE

There is both clinical and laboratory evidence to show that prolonged recumbency may be harmful in certain patients with heart disease. One needs only consider the known normal and pathological physiology of the human body, particularly those facts concerning the heart and vasomotor system in general, body fluids, and oxygenation of tissues among many others. The ever present threat of pulmonary emboli and thrombosis of peripheral veins associated with this syndrome under condition of enforced long standing rest are too well known to discuss any further. Aggravation of the existing pulmonary congestion is not too unusual in this type of management also. In general, it may be stated that under certain circumstances, recumbency has been shown to increase rather than decrease the work of the heart. Even in severed compensation, especially those with nocturnal dyspnea, we can very early institute sitting on the edge of the bed, or in a chair, plus active motion of arms and legs together with deep breathing. This may definitely be used for supervised periods of time in the treatment and convalescence of congestive heart failure.

When compensation has been established, our job is not yet finished. We must recondition and rehabilitate this patient. Work commensurate with his cardiac reserve must be recommended. Industrial studies have clearly demonstrated that many cardiacs have been the most productive elements in various units, and industries in general have done an about-face from the old days when they refused to employ a known cardiac in any status. These patients must be made to feel a definite responsibility to themselves and society and not led to believe their course is run and be allowed to vegetate. As a physician that is your responsibility. Discuss his work capabilities with him during his convalescence so that he can intelligently plan his course in the future. Obviously one must consider factors such as age, mental capacity, and organic factors behind the decompensation. In other words, each case is an entity unto itself and the physician's common sense and medical knowledge are invaluable in making these decisions.

RHEUMATIC HEART DISEASE

This includes both myocarditis and endocarditis, complicating acute rheumatic fever. One must never forget that the tendency for chronicity and recurrence of this disease makes the problem of convalescence and return to advised normal a very delicate one. The opinion as to activity of the acute disease is difficult to prove in many instances, even with astute clinicians using every faculty at their command.

No one can deny that in proved cases of cardiac involvement in rheumatic fever, the treatment must be bed rest until the sedimentation rate, fever, leukocytosis, and joints have returned to normal. But here again progress has been made using a carefully-graded exercise in bed plus training in mental and manual dexterity. In uncomplicated carditis, the sedimentation rate and EKG are of invaluable assistance in making the decision of activity, although we must not lose sight of the fact that these can be misleading at times.

Here may I make an earnest plea for correct diagnosis so far as residual valvular complications in rheumatic fever are concerned. You must make each case fit the criteria, both clinically and in a laboratory manner, and careful attention must be paid to history. Another fact not to be forgotten in making this impression is the question of time lapse from the onset of the disease. Do not be in too big a hurry to tell a patient he or she has a "leaky heart" as a result of rheumatic fever. This is a much abused old story and one that we see frequently both in the Army and in civilian life.

In proved cases during convalescence, we can use many tests to determine the cardiac efficiency, but the most recent one applied by the Army and Navy has been the two-step test or some modification of it. This is carefully used in graded amounts and is followed by graduated, supervised physical training. Our common procedure is to have a conference with the patient after we have studied him and tell him the facts about the "leak in his heart". Assurance is given him that if he will avoid abuse of his body he may look for a fairly normal life expectancy. Inquiry is made as to his civilian status and he is told that he should aim towards earning his living with his brain instead of his brawn. We also tell him that he can consider himself as a batter

in a baseball game in which he has used one of the three strikes allowed him and has only two remaining, and that he should look over the remaining ones very carefully. He is told to have his heart and general condition evaluated and checked every three to six months in the same manner that he would run his automobile in for a road checkup. This program has borne big dividends for us.

CORONARY INSUFFICIENCY

Many factors must be taken into consideration in discussing the convalescence, rehabilitation, and reconditioning of this class of cardiac patient. Among these are age, severity, and location of the infarct, presence or absence of hypertension, mental attitude, previous job qualifications, general body health, and co-existing diseases. We must first of all assume the patient is recovering from the original insult to the myocardium and that no immediate complication such as acute decompensation, arrhythmias, heart block, and thrombi or emboli formation have occurred, all of which are grave prognostic signs. The careful and searching evaluation of each individual case must of a necessity precede our plan or regime to be followed in conducting this patient back to health and usefulness.

The observation that some people are able to continue their normal activity even though it is strenuous in spite of the occurrence of acute myocardial infarction, is not new. Well controlled studies as far back as 1940 have shown that in 415 patients who survived acute coronary occlusion with myocardial infarction, the incidence of heart failure, subsequent infarction or death was not any greater among those who returned to work than those who did not. We are not predicating that every person who suffers the above syndrome will recover sufficiently well to return to work, but that many can be salvaged with proper management has been demonstrated over and over again.

Certainly after three weeks have elapsed, all other factors being equal and the danger of cardiac rupture and aneurysm having passed, we can begin to allow the patient to carry out the regime we have discussed in the management of congestive heart failure. Obviously the sedimentation rate and EKG are of invaluable assistance during this period as well as the subjective and objective findings. Supervised graduated exercises are next in order until one is accurately able to obtain an index of the cardiac reserve of the patient by accepted methods. It is interesting to note that many patients learn their own limitations subjectively much better than we are able to estimate and demonstrate them. These are fortunate people in that they are able to guide themselves accordingly. After the establishment of their work capabilities, it becomes a part of your responsibility, as mentioned previously in this discussion, to guide and counsel the patient as to the type and amount of work he should do and his general over-all mode of life. In other words, the physician is not only a valuable factor in the treatment of the acute episode but also in the restoration of the patient to his calculated normalcy.

A great deal of carefully evaluated work has been done by several workers and clinics in considering the problem of occupations for heart cases. We can express the result of these investigations by stating that the problem has boiled down to two classifications. The first classification pertains to the functional capacity of his heart and this is arrived at from the patient's appraisal of his ability to perform physical activity plus the physician's careful evaluation. The second classification is based on the evaluation of occupation according to the amount of physical labor involved, including the number of working hours per week, the amount of lifting, climbing, carrying, traveling time, etc. The work limitations of cardiacs must be analyzed in terms of actual occupations and a classification of clerical, skilled, and semi-skilled, etc., is not sufficient. Above all, these cardiacs must be carefully followed, subjectively and objectively if they continue in their work capacity.

In illustration of our thesis, it might be well to quote specific cases in a brief manner:

Two patients recently followed in our Class III Medical Company can be used for this purpose. The first case was that of a 39 year old Filipino who spoke but little English and had worked most of his life as a cook in restaurants of the poorer type. He had no formal education and his Army career consisted of being a cook and cook's helper. He suffered an acute coronary occlusion followed by acute congestive heart failure in August, 1945, in the Southwest Pacific Area. On arrival here, his cardiac reserve was only fair and not suitable for physical labor of the type he did before entry into the Armed Forces. He has one sister living in Chicago and no other living relatives. It is necessary that this man be self-supporting to a certain extent at least. One can readily appreciate the problem here and fully realize the importance of using the efforts of the entire team along the lines discussed above.

The second case is that of a 42 year old S/Sgt who has been in the regular Army 19 years. He suffered an acute coronary occlusion about one year ago and had a recurrence within 3 months after that. At present his subjective and objective calculated cardiac reserve is not good. He is married, has a daughter of Junior High School age, owns a small home and several acres of land in Arizona which are suitable for farming and contains an orchard. He desires

to raise chickens as his hobby. In one year or less he is eligible for retirement with full pension. You can all readily differentiate his problem from the preceding one. We have used these two authentic cases to show you the extremes we encounter in this Convalescent Hospital, and each case presents very clearly the need not only for the best in medical care but also the need for expert follow-up through reconditioning and rehabilitation.

CARDIOPHOBIA

A large number of the cases that come through our cardiac company and that we see in consultation, are made up of those who have been incorrectly diagnosed and erroneously told that they have "heart trouble". By the time they arrive at the Convalescent Hospital level, they have passed through several hospitals. At each installation the story is repeated until by the time we get them they are confirmed cardiophobes suffering with shortness of breath, pains in their heart, sleeplessness, weakness, dizziness, hot and cold spells, and a host of other pseudo-cardiac complaints. In all cases, our first procedure is a thorough and searching history and physical examination. Usually two of us who have competent cardiac training see each case in order to eliminate a personal factor of error. We then proceed to investigate sedimentation rates, EKG studies, including many before and after exercises, and cardio-fluoroscopy with oesophograms. Clinical study of the patient under effort is also made. The Neuropsychiatric Department evaluates the general psychic picture for us to complete the study.

Then begins the specific problem of guiding this man's mind and body towards his restoration to normal. One must frankly discuss the reasons for changing the patient's diagnosis without implicating or blaming any doctor or hospital. You must discuss in lay terms the heart and its workings and fundamentally you must prove your diagnosis to the patient by any and all means, particularly demonstrating to him that he can participate in normal physical activities of his age level. Many times you find in his history a potent factor showing the background for the patient's fear of heart disease. This must be discussed and oriented properly in his mind and frequently the correction of this factor alone will suffice to set the patient on the right path. The assurance that he has no heart disease must be thoroughly sold and agreed upon by the patient. You can tell if he just says he believes you or if he really means it and believes it. Unless you feel that he is in complete accord with your assurances you have not completed this patient's reconditioning and rehabilitation.

Thus we see a new trend of thought has arisen, which is a radical departure from our long established procedings relating to cardiac disease. Rather than treatment, I prefer the term "management," in thinking of this new concept for it truly demonstrates just that. From the first day of illness we are planning the over-all campaign of our cardiac patient in his return to a productive level, mentally and physically. May I again state that this is an individualized management and not a generalized one, and depends on the unselfish hearty cooperation directed by the physician primarily, but aided by educators, industry, and a host of others working together as a unit. No attempt has been made to specifically state facts, figures, or research workers' names in this paper. These can be identified by a careful perusal of the attached bibliography. Rather it has been our purpose to present the cardiac in a new light; namely, not as a "has been" or a "fireside fixture," but as one who can be made into a useful, productive member of society.

BIBLIOGRAPHY

1. Levine and Phillips: Coronary Occlusion in Industry. American Heart Journal, May, 1945.

2. Kresky and Goldwater: Occupations for Heart Patients. American Heart Journal, May, 1944.

3. Harrison, Tinsley R.: Abuse of Rest as a Therapeutic Measure for Patients with Cardiovascular Disease. J.A.M.A., August 19, 1944.

4. Levine, Samuel L.: Some Harmful Effects of Recumbency in the Treatment of Heart Disease. J.A.M.A., Sept. 9, 1944.

5. Woods, Robert M., and Barnes, Arlie R.: Factors Influencing Immediate Mortality After Coronary Occlusion. American Heart Journal, July, 1942.

6. Symposium on Rehabilitation. Medical Clinic of North America, May, 1945.

7. Master, A. M., Commander, MC, USNR: The Two-Step Exercise, a Test of Cardiac Function and Coronary Insufficiency. American Journal Medical Sciences, April, 1944.

8. Barbes, Arlie R.: Rheumatic Fever, a Summary of Present Day Concepts. Medical Clinics of North America, July, 1945.

9. Aagaard, G. N., and Watson, G. J.: Restriction of Activity in Coronary Occlusion with Particular Reference to the Extent of Myocardial Infarction. Medical Clinics of North America, March, 1945.

10. Williams, Conger, and White, Paul D.: Disease of Heart and a Review of Significant Contributions Made During 1943. Archives of Int. Med., June, 1944.

Antibiotics

The future of antibiotics is certain. What the new developments are to be is questionable, but the possibilities are great and almost endless. Fleming himself does not believe that penicillin will be the only clinically important antibiotic or even the best. We have two agents, penicillin and streptomycin, which will control infections by most of the gram-positive and gram-negative infections for which there was little or no treatment ten years ago. As yet, the problems of the virus infections and the walled-in chronic infections are to be solved.—D. F. Marsh, Dept. Pharm., W. Va. Univ.; W. Va. Med. Jr., Vol. 42, No. 4, April, 1946.

Thoraco-Lumbar Sympathectomy Operation for High Blood Pressure

G. C. ULLERY, M.D.

ONLY a year ago one would wise crack, "Have you had your vitamins today?" Now you will hear, "Have you had your penicillin today?" Tomorrow it will be, "Have you had your streptomycin?" Just yesterday I stopped to chat with a little nurse in an equipment room. There she was cleaning fifty syringes for penicillin. This was for one floor of the hospital only.

As I look back, how did we ever get along? The two operations that intrigue me today are the sub-total gastrectomy and the thoraco-lumbar sympathectomy for essential hypertention. How we used to throw out our chest when we did a gastro-enterostomy! Now, I feel that I have not done justice to my patient unless I have done the sub-total gastrectomy as this is the operation of choice. As to thoraco-lumbar sympathectomy, it is unusually safe if the proper details are carried out. Of course, these cases should be properly prepared and we must be sure that arterio-sclerosis is not present since in that case we can not dilate the blood vessels which is the definite purpose of the operation.

THE OPERATION

A brief description of the operation follows: A table that breaks or bends in the middle is preferred. The patient is prepared for a major surgical procedure. The draping and position of the patient is similar to that for a nephrectomy or kidney operation, as this is a double operation done in two stages about seven or eight days apart. The left side is usually done first hence the patient is placed on the right side, table bent, patient on blankets. The bend in the table will elevate the middle portion of the body. The patient is held in position by adhesive tape over the shoulders, upper chest and hips; the adhesive fixed to the table. This holds the patient to the table most securely.

The exagerated kidney incision is used. The eleventh rib is dissected free and removed near its articulation to the spine. Then the peritoneum below the diaphragm is elevated by careful dissection with a small sponge on a sponge-holding forceps. The first assistant, who is on the opposite side of the table, will keep constant retraction on the peritoneum and kidney. As the kidney is also elevated with this firm retraction, the peritoneum is readily elevated and the sympathetic ganglia is exposed and identified as it courses down along the spine.

After the ganglia are well exposed and identified, then the same procedure is carried out by the same technique above the diaphragm, the first assistant elevating the lungs and heart by the special elevators. Then the pleura is dissected free and the sympathetic ganglia are here well identified. After this dissection is well carried out, then the ganglia below the diaphragm are freed by uterine dressing forceps which hold a tiny sponge. One can brush the ganglia loose with all their ramifications but leave the chain intact. I might mention here that all instruments are long ones, long hemostats, long scissors and bone forceps, as one is working in a deep cavity. Worthy of note also is the danger of lacerating one of the great veins in the chest or abdomen. However, with care and a good anatomical knowledge, there is not much danger.

After the ganglia are freed in the chest and abdomen, from about the fourth dorsal to the first or second lumbar, then the diaphragm is severed and the ganglia are freed where they pass through the diaphragm. At this point one should excise a tiny piece of the kidney for biopsy to determine any kidney damage. Now the diaphragm is resutured by interrupted cotton suture material. Here a small catheter is placed back of the lungs and, after the wound is closed securely, a 50 cc. syringe will aspirate all air back of the lungs through the catheter as it is withdrawn. The wound is closed by interrupted sutures of cotton. In 7 to 10 days the same procedure is carried out on the opposite side.

The postoperative treatment is the same as all other major surgical procedures. The patient should be in the hospital about three weeks. This operation is here to stay. It is unusually safe. The patient should be well prepared. The patient should be informed that it will cause impotency.

Submitted January 26, 1946.

The Author

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Ileus Complicating Infectious Hepatitis—A Case Report

JAMES D. NELSON, M.D.

THE following case report is presented because of its unusual and bizarre clinical course, and because it brings to light complications of hepatitis which heretofore I have not seen reported.

History: A 21-year old private first class was admitted to a general hospital July 29, 1945, because of first and second degree burns of the right leg, left arm, neck and shoulder which occured overseas on April 29, 1945, when a gasoline stove exploded. Following the accident, the burns were treated by débridement, vaseline gauze, three units of plasma intravenously and morphine sulphate .016 gms. hypodermically. His progress was uneventful until June 17, 1945, when it was necessary to perform a skin graft on his right leg. Because of the extensive area involved and prolonged time required for healing, he was returned to the zone of interior for further hospitalization. The past and family histories are non-contributory.

Physical Examination: Physical examination revealed a well-developed and fairly well-nourished adult white male, ambulatory, and apparently comfortable. There were healed burn scars involving most of the anterior chest, left side of the neck, left arm to the elbow, and proximal two-thirds of the right arm. The medial surface of both legs, upper and middle thirds, presented healed burned areas. Several areas on the anterior and lateral surfaces of the right leg were in a healing state following skin graft. The temperature was 98 degrees Fahrenheit, pulse 80, and blood pressure 120 systolic and 80 diastolic. Examination of the heart, lungs and abdomen revealed no abnormality.

Laboratory Studies: Red Blood cells 3,770,000; white blood cells 8,600, hemoglobin 13.5 gms., neutrophils 44, lymphocytes 53, monocytes 2, and eosinophils 1. The serum protein was 5.62 gms., and Kahn negative.

Course: This patient seemed to be doing well and the burned areas completely healed within a few days after admission. His only treatment was physiotherapeutic measures to prevent contracture deformity resulting from cicatrix formation. On August 23, he complained of general malaise, anorexia, headache and a pain in his epigastric region. These complaints persisted and on August 26 nausea and vomiting developed. The anorexia increased, as did the abdominal discomfort.

He was seen by a medical consultant who made a diagnosis of acute infectious hepatitis on August 27, 1945. At this time the temperature pulse and respirations were normal. A definite icterus of the sclerae was present, the liver was enlarged three centimeters below the right costal border and was tender. The abdomen appeared moderately distended. One thousand cc. of 10 per cent glucose in normal salt solution was given by vein, and supplementary feedings of sweetened orange juice were prescribed. Laboratory studies showed red blood cells 4,120,000, white blood cells, 5,000, hemoglobin 14 gms., neutrophils 78, lymphocytes 20, and monocytes 2. The urine contained 1+ albumin, and one to three finely granular casts per high power field. Bile was present in the urine and urobilinogen was present in a dilution of one to 30. The icterus index was 60.

Th malaise, nausea, and vomiting continued and the abdominal discomfort became more severe. The abdominal pain shifted from the epigastrium to the right upper quadrant, and over this area there was considerable tenderness. Abdominal distention became marked and peristalsis could not be heard. Because of the persistent vomiting an X-ray of the stomach and duodenum was made on August 28. This report stated that a small amount of barium entered the base of the duodenal bulb, but none could be expressed beyond that point. In one and one-half hours 100 per cent gastric retention was observed and in four hours about 50 per cent retention was present. At this time, some of the descending portion of the duodenum was outlined, but a long segment beginning at the apex of the bulb was markedly narrowed. Differentiation between spasm, obstruction by extrinsic pressure and intrinsic disease was not made on these films and a repeat examination was advised.

The patient continued to have intractible nausea and vomiting, and distention of his abdomen increased, particularly in its upper half. Along with the distention, there were signs of fluid in his abdomen. The peristaltic sounds were almost absent. On September 1, a Wangensteen tube was placed into the duodenum and pitressin was given hypodermically three times daily. There was a slight and temporary improvement in the nausea, but the abdominal distention and pain continued. Between August 28 and September 2, he had one small clay colored stool.

The X-ray study of the stomach and duodenum was repeated on September 1, following the hypodermic injection of 1/150 gr. of atropine sulphate three times daily for two days. The report of this study was normal except for failure of visualization of a segment of the duodenum 5 cm. long just beyond the bulb. During the following two weeks, the course of his illness changed very little. Right upper abdominal pain and cramps persisted, distention remained despite the use of pitressin, turpentine stupes,

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Wangensteen tube, et cetera. Nausea and vomiting were persistent when any attempt at food intake was made. He was given supportive treatment during this period, consisting of 5 per cent glucose in normal salt solution, vitamin supplements, amigen by vein, bile salts and such liquids as he could occasionally tolerate by mouth.

On September 12, his icterus index was 83, van den Bergh was positive direct, 8.75. The blood cholesterol was 138 mgs. with 47 per cent esters. The sedimentation rate was 55 mms., the prothrombin time was 33 seconds with 25 seconds as normal control. The urobilinogen content of the urine was not determined. The patient looked toxic and had obviously lost weight. At no time had he been febrile. Because of the failure to improve over a period of three weeks, and with persistent and increasing abdominal distention and equivocal X-ray findings of the duodenum, an exploratory laparotomy was performed on September 14, 1945.

Report of Operation: Nitrous oxide, oxygen, and ether anesthesia was employed; 1,900 cc. of bile stained fluid was removed from the abdomen. The liver appeared firm and presented no nodules. It was enlarged two fingersbreadth below the costal border. The stomach showed no abnormality. The duodenum was edematous, as was the hepato-duodenal ligament. The gallbladder was markedly distended and was pressing on the duodenum, apparently causing the edema and abnormal appearance of the duodenum noted on the X-ray film. A cholecystotomy was performed and 60 cc. of yellow, viscid bile was removed. An indwelling Foley catheter drain was placed in the gallbladder. Following the operation, the patient's recovery was slow but uneventful. All evidence of intestinal atony was rather promptly relieved after the operation. The clinical recovery from his hepatitis, as well as the return to normal of the liver function studies, followed the course of the average case of hepatitis, and at present, there is no physical finding or laboratory study that would lead one to suspect residual damage from this illness.

DISCUSSION

This report brings to light two important observations: First, that complete and prolonged ileus can complicate hepatitis; and, second, that the seat of pathology in infectious hepatitis is not confined necessarily to the hepatic cellular substance, but may go on to involve the terminal bile passages and adjacent tissues. This latter fact is sometimes overlooked. The symptoms associated with hepatitis are numerous and variable, and such complicating factors as bleeding phenomenae, ascites, abdominal cramps, diarrhea, abdominal distention, severe nausea and vomiting and weight loss are not remarkable. Yet the persistent and pronounced abdominal distention in this case, being refractory to the ordinary measures of treatment is unusual. Moreover, the anatomical changes created by involvement of the terminal bile passage was, in this instance, unique.

In retrospect, one might question the indication for surgery, and others might feel that surgery should have been resorted to earlier. This is, of course, a matter of conjecture. To be sure, acute infectious hepatitis is a medical problem and should be treated medically. The recovery following surgery in this instance is considered to be purely coincidental, and it is felt that the patient would have recovered as rapidly, if not more so, had surgery not been employed. The difficulty in this case arose from being unable to exclude a mechanical obstruction as the cause of his jaundice.

SUMMARY

A 21 year old private first class was admitted to a general hospital on July 29, 1945, because of first and second degree burns of his neck, shoulder and extremities which occurred overseas on April 29, 1945. The burned areas rapidly healed and his recovery was uneventful until August 23, 1945, when he developed epigastric discomfort, anorexia and general malaise. A diagnosis of acute infectious hepatitis was made, and the usual medical therapy was employed. Marked abdominal distention developed and persisted despite the use of pitressin, Wangensteen suction and intravenous fluids.

An X-ray study of the duodenum revealed equivocal findings that suggested a mechanical obstruction to the flow of bile. Because of the persistence of his abdominal distention for three weeks, and in view of the inconclusive X-ray examination, an exploratory laparotomy was performed. The gallbladder was found to be distended and producing pressure on the duodenum. There was considerable edema involving the duodenum and hepato-duodenal ligament. Following the operation the patient's recovery was uneventful, but it was not felt that surgery contributed to his recovery. The only justification for operation was the inability to exclude a mechanical obstruction as the cause for his jaundice.

Treatment of Migraine and Related Headaches

The majority of patients affected with severe headaches show signs of metabolic disorder which can be diagnosed by the salt-tolerance test and demonstration of salt and water retention.

The retentional type of headache responds in the large majority of cases to a simple treatment consisting of a high-protein diet with restriction of salt, water, and carbohydrate intake and to medication with ammonium and organic potassium salts. Sedation with a mixture of atropine and phenobarbital is also necessary. Added therapy with endocrine preparations should be considered if warranted by evidence of endocrine deficiencies.—M. A. Goldzieher, M.D., New York City; N.Y. S. Jr. Med., March 1, 1946.

Brain Abscess Associated with Congenital Heart Disease

THOMAS L. RAMSEY, M.D., and VINCENT T. MOSQUERA, M.D.

BRAIN abscess in patients with congenital heart disease is not uncommon. Premortem diagnosis is not as frequently established as it should be. Several cases have been reported in which a premortem diagnosis was made.

Smolik, Blattner, and Heys,[1] St. Louis, recently reported a case of brain abscess associated with congenital heart disease in which a complete recovery seemed to have been accomplished. The authors analyzed the association of brain abscess with congenital heart disease and called attention to a comprehensive report by Robbins of 26 cases. Three of the 26 were associated with the tetralogy of Fallot. Robbins[2] reviewed 58 cases of congenital heart disease in a series of 7,880 consecutive autopsies. In only three instances the diagnosis of brain abscess was made ante-morten and surgical intervention attempted.

In the case we report, a tentative diagnosis of brain abscess was considered and the necessary arrangements were made to confirm the diagnosis but the patient expired before this could be attempted.

CASE REPORT

This 26 year old patient sought medical attention on Dec. 16, 1945, complaining of severe left frontal headache of some days' duration. The patient was afebrile with no elevation of the pulse rate. Examination of the nares at that time disclosed no striking inflammation or swelling of the nasal mucosa.

Patient received phen. aspirin and caffeine compound reinforced with codeine in ½ gr. dosage (p.r.n.) for pain.

The patient on the following day was found afebrile and the pulse was normal. He was still suffering from his frontal headache whenever the effect of codeine diminished. In the evening of the same day the patient had a generalized convulsion, and appeared like an epileptic after a grand mal attack, being dazed and sluggishly irresponsive to questioning. He then had a degree or so of temperature with corresponding pulse increase. The reflexes were all hyperactive but none pathologic. There was a suspicion of beginning neck rigidity. A meningitic involvement was considered at that time. He was sent to the hospital with an admission order for 40,000 units of penicillin.

Past history: Patient stated that a congenital lesion of the heart was diagnosed shortly after his birth and that his existence was considered precarious throughout his childhood and into puberty. He spent one whole year during childhood confined to bed in his home because of his heart condition. After puberty he appeared to have outgrown the disability associated with his heart sufficiently to earn his living as a greenskeeper on a golf course during the day and as a bartender during some hours of the night.

Physical examination: Revealed a well-developed, well-nourished white male lying in bed in no great discomfort. His temperature was 101° oral; pulse 95; respiration 24. Pupils reacted to light and accommodation. There was some cervical rigidity. A loud systolic murmur was heard all over the precordia but loudest at the apex. The lung fields were clear. The abdomen was negative. Reflexes: Superficial present and active. Deep present and markedly hyperactive bilaterally. No clonus. Pathologic toe reflexes absent. Clubbing of all fingers and toes was noticed.

Laboratory findings: From Dec. 19, 1945, to Jan. 2, 1946, several examinations of spinal fluid were made. The cell count varied from 750 to 3,600. Differential always revealed a high number of polymorphonuclears, about 65 to 75 per cent. Pandy's was ++++. Sugar determination varied from 31.2 to 90.8 mg. per cent. Blood cultures were negative.

Spinal fluid cultures showed no growth on several occasions and direct smears revealed no organisms, however on the specimen received a day before the patient expired the direct smear showed a few gram-negative and gram-positive cocci in pairs and short chains. On Dec. 23, 1945, sulfadiazine level was as high as 19.5 mg. per cent. Urinalysis after administration of sulfadiazine showed albumin, numerous RBC, a few epithelial cells and crystals resembling sulfa. Complete blood count on different occasions showed a normal number of red cells. The hemoglobin was normal. The WBC varied from 12,100 to 12,950. Differential counts showed no significant changes.

X-ray findings: Stereoscopic views of the paranasal sinuses were made and both Waters and the Caldwell projections showed the sinuses to be normally radiolucent. There was no evidence of bone destruction in the facial bones.

Treatment: From Dec. 17, 1945, to Dec. 23, 1945, the patient received 45.75 gms. of sulfadiazine by mouth combined with sodium bicarbonate and 4.5 gms. of sulfadiazine intravenously, also 1,720,000 units of penicillin. At this time sulfadiazine was stopped. From Dec. 24, 1945, to Jan. 2, 1946, penicillin was continued and 750,000 units were administered. During the days of patient's stay in the hospital aspirin and codeine were used p.r.n. to relieve pain.

Course and consultation notes: On Dec. 17, 1945, Spinal tap revealed an initial pressure of 180 mm. water. Pressure bilaterally on jugulars caused a rise to 250 mm. The fluid was "ground-glass" in appearance. On Dec. 21, 1945 initial pressure of spinal fluid was 180 mm. water. After withdrawal of 15 cc. of spinal fluid, pressure was 120. The fluid was frankly purulent. On Dec. 21, 1945, the patient had severe headaches. Aspirin and codeine were ineffective. The pulse rate was 64 and the temperature was 97°.

Another physician, called in for consultation on this day, made the following report as to diagnosis and treatment: (1) Meningococcic meningitis was considered with the possibility of fair recovery. (2) Encephalitis. The findings,

Selected by Thomas L. Ramsey, M. D., Department of Pathology, St. Vincent's Hospital, Toledo, as one of a series of cases being published under the heading of "Case Records Presenting Clinical Problems".

however, are not entirely applicable to such a diagnosis in this case. (3) Previous headaches with mental dullness and fluctuating temperatures would suggest possibility of a left temporal lobal lesion, probably an abscess. Periodic neurological examination should be made to establish definite diagnosis.

On Dec. 31, 1945, another spinal puncture was performed. The initial pressure was 275 mm. water rising to 360 mm. with jugular compression; 7 cc. of fluid was withdrawn and the pressure reduced to 90 mm. water. Fluid showed some flocculent precipitate but the fluid itself appeared crystal clear.

On Jan. 2, 1946, the patient asked for a lumbar puncture to relieve his headache. The puncture revealed an initial pressure of 175 mm. water rising to 200 mm. with jugular compression. About 3 to 4 cc. was withdrawn when the patient became alarmingly cyanotic and started to chill. The tap was discontinued after the pressure had dropped to 110 mm. The patient's condition was immediately alarming and coramine was administered. The cyanosis abated but the patient showed signs of waning consciousness and incipient coma. Generalized spasticity was apparent. The patient became comatose and the left pupil dilated fully. The respiration became stertorous, and the axillary temperature rose to 107°. The patient expired 7 hours later.

AUTOPSY

We will mention only the significant anatomic observations. There was clubbing of the fingers and the toes. The right lung weighed 920 gms. It showed marked edema and congestion of the upper lobe. The left lung weighed 650 gms. and showed some congestion of the lower lobe.

The heart with the first portion of the aorta weighed 485 gms. There was eccentric hypertrophy of the left and right ventricles. The right ventricular wall was about 15 mm. in thickness near the base. The foramen ovale was patent and measures 20 mm. in size. There was no interventricular defect. The pulmonary artery showed no abnormalities. The aorta was small and narrow. The ascending portion measures 35 mm. in circumference. The innominated artery rose from the convexity of the arch and measured 3 cm. in length and 20 mm. in circumference. The right common carotid and right subclavian arteries appeared smaller than normal. The left carotid and subclavian arteries showed similar changes. The ductus arteriosus was closed.

The liver showed a cavernous hemangioma, 4 cm. in size. Mesenteric lymphnodes were markedly enlarged and each measured 15 mm. in size. Removal of the calvarium showed slight increase of the subarachnoid fluid.

An abscess was found in the left occipital lobe about 2 cm. from the end of the lobe. The abscess measured 5½ cm. in length and appeared well circumscribed. The pia matter in this area showed some inflammatory reaction. On opening the left lateral ventricle some purulent material was seen, apparently coming from the abscess. Cultures were taken from the abscess using a sterile needle and syringe and a sanguino-purulent exudate was obtained. No rupture had occurred through the brain cortex.

The organ was placed in formalin for fixation and further study. Examination of middle ear and sinuses revealed no gross pathology. After 23 days of fixation, the brain was sectioned. The abscess measured 5½ cm. in length by 4 cm. in the widest diameter. It was well circumscribed and encapsulated. The wall was fibrotic. The brain cortex over the abscess was thinned to about 3 mm. in thickness. The cavity of the abscess contained necrotic brain tissue and purulent material. Smears were taken for bacteriologic study. A small orifice was found communicating between the abscess and the left lateral ventricle.

Bacteriological reports: Before fixation of the brain the cultures showed a growth of Streptococcus viridans also Hemophilus influenzae. Direct smears showed many leucocytes and gram-positive and gram-negative cocci in pairs and in chain formations. After fixation, gram stained and methylene blue smears showed many leucocytes and long chain streptococci.

Microscopic examinations of tissues: The lungs showed acute congestion and edema and chronic emphysema. The alveolar capillaries were markedly congested throughout the entire tissue of the upper lobe. The walls of the alveoli were thickened. The capillaries of the bronchioles and pleural surface were also affected. The cells lining the alveoli were for the most part normal, but some were swollen. The majority of the alveoli were empty but many showed a content of pinkish stained lymph in which some red cells were present. There were also some polymorphonuclear leucocytes and histiocytes. One area from the liver showed the typical structure of a cavernous hemangioma.

Sections from the wall of the abscess showed the innermost layer formed by leucocytes in various stages of necrosis. Between the brain substance and the abscess cavity there were macrophages with proliferating fibroblasts and round cell infiltration; some of the cells show evidence of phagocytosis. There were many bacterial clumps in the lining of the cavity which were surrounded by polymorphonuclear leucocytes, lymphocytes, and plasma cells. Some bacterial clumps were found in the cavity of the abscess. Bacterial stained sections revealed large groups of streptococci.

COMMENTS

This case is presented to emphasize the importance of symptoms of cerebral nervous system involvement in congenital heart disease as a significant factor suggesting a diagnosis of brain abscess. Forbus[3] mentions sudden death in brain abscess due to rupture of the abscess into the lateral ventricle. The symptoms presented by our patient during the last spinal tap could have been due to such a rupture. The cause of death, we believe was due to toxic changes and cardiac and respiratory failure in a patient with congenital heart disease associated with brain abscess.

SUMMARY

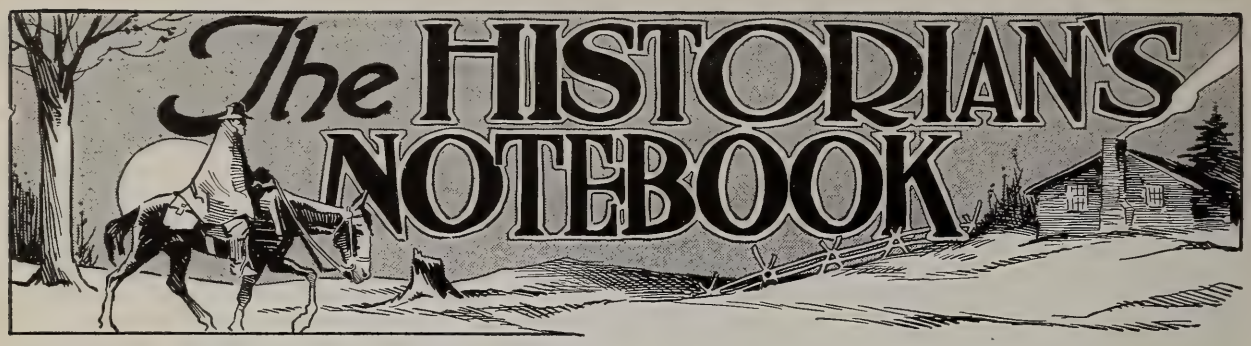
A fatal case of brain abscess with congenital heart disease is reported in which a tentative diagnosis of brain abscess was made.

BIBLIOGRAPHY

1. Smolik, Edmund A.; Blattner, Russell J.; Heys, Florence M.; St. Louis: Brain Abscess Associated With Congenital Heart Disease, J.A.M.A., 130:145, Jan., 1946.

2. Robbins, S. L.: Brain Abscess Associated With Congenital Heart Disease, Arch. Int. Med., 75:279, May, 1945.

3. Forbus, Wiley D., Prof. of Pathology, Duke University, and Pathologist to Duke Hospital. Page 158. The Williams & Wilkins Company, 1943.



Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio

The Vaulting Imagination of John L. Riddell

ADOLPH E. WALLER, PH.D.

(Continued from the April issue)

RIDDELL HERBARIUM SPECIMENS IN LLOYD LIBRARY

In Cincinnati, there is not a great deal on record about Riddell. The librarian of the Lloyd Library has a collection of Riddell plants[17] in an excellent state of preservation. By correspondence it has been established that there were later collections made of plants in Texas and in other places. But Riddell herbaria, citing dates and places of collection, are virtually non-existant. When he published he did not retain the collections to verify his lists. They were the specimens he sold and which are scattered without record of the purchasers.

In Baton Rouge, Riddell arranged to manage Mary's proporty. He established that her father's name was Knock. He does not record exactly what the property was worth or how it was to be administered. But his records show that presently he is established in a home of his own in New Orleans. The Medical College of Louisiana was at one time located at University Place. Where the building stood there is at present a parking lot adjacent to the Roosevelt Hotel. The Riddels lived in a house on Canal Street about two blocks away.

RIDDELL SUCCEEDS WILLIAM BOYD POWELL IN CHEMISTRY

Riddell apparently was able to complete his several business engagements quite rapidly. In 1836, he was appointed to the position which had been held by William Byrd Powell, Professor of Chemistry in the Medical College of Louisiana, which in Riddell's obituary in the *American Journal of Science*[18] is indicated as his second appointment to a college position. All mention of Worthington is omitted. In somewhat similar fashion the *Dictionary of American Biography*[19] does not go back of 1835. Absorbed in a new life of matrimony, of financial competence, of teaching chemistry, of medical practice in New Orleans there is not much mention further of Mary, nor is it certain just when he visited Cincinnati and Ohio to complete the work with the Geological Survey. After Dr. Hildreth's original report, W. W. Mather was appointed principal geologist, but all the members of the preliminary committee were retained including Hildreth, Riddell, Lapham and Locke. Others were added.[20] When Hildreth resigned, with Riddell so far away, Lapham about to leave the State and Locke on an educational tour in England, the plans for a geological survey of the State of Ohio were ruined.

JOURNEY IN TEXAS

Riddell explored Texas in 1838. The account of this is given in the Journal and is worth a separate monograph. When he returned he was appointed melter and refiner at the New Orleans branch of the United States Mint.[21] He at once came into dispute with some of the subordinate employees of the mint and he accused one of them of stealing silver and discharged him. He devised a more accurate system of accounting for both gold and silver bullion. The discharged employee accused Riddell of assaulting him and as Riddell admitted this, he was sentenced to jail. The judge, however, did not oblige Riddell to remain in jail since the operation of the mint

The Author

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Fig. 1. One of Two Microscope Designs on which Riddell Worked (Courtesy of U. S. Army Medical Museum. Neg. No. 41934).



Fig. 2. Riddell's Stamps Issued during the Confederacy. Of Interest to Stamp Collectors.

would have been suspended. Eventually the case came to the attention of President Tyler who made Riddell's appointment a personal one. Although this trolble seems to have made some enemies for Riddell, the manner of his appointment heightened the opinion of him among his New Orleans friends. He obtained a position for his brother, George, at the mint and brought his mother and sister to live in New Orleans.

Mary became ill about that time and died of tuberculosis. He writes of it briefly and grieved for her as a loving wife and mother. She had borne two sons, John, who died in infancy, and Sanford. He was glad to have his mother and sister with him. More and more, however, his personal Journal takes on the character of the Repository. It records only the more important events of his life and as such it ceases to interest him and presently it becomes more like a scrap book with clippings of letters he had written to the papers and with the usual omissions that an imperfectly kept scrap book show.

At this time, he was wealthy enough to pay around eight hundred dollars for a negro slave whom he describes as a cook. He also mentions a girl who had recently arrived from Holland as a nurse for his son, Sanford. When later his mother complains to him that he is showing too great familiarity in his manner toward the girl and insists on his dismissing her, he tells his mother that he is reluctant to let her go as she has no other way of earning a living. He does, however, dismiss her on the "ostensible ground that she cannot talk English" to his son.

About 1845 to 1850 he is married to Miss Angelica Brown. Three daughters were borne of this marriage, Lephe, named for Riddell's mother, Mary, named for his first wife, and Susan.

ANTEDATES VIRCHOW ON IDEAS OF CONTAGION

Although he retained his professorship with ever increasing popularity until his death and his position of melter and refiner at the mint until 1849 and presumably increased his medical practice he, nevertheless, found time for additional duties. In 1844, the governor of Louisiana through legislative authority appointed Riddell a member of a commission to plan to protect New Orleans against Mississippi River floods. Riddell also began to study the water of the river microscopically. It may have produced some ribbing and some merriment on the part of the other members of the commission but Riddell was beyond the days when he had to try to seem mysterious and develop the "*hauteur*" he wished to use at Ogdensburg. In 1836, he embraced the ideas learned from Hildreth and Daniel Drake. "I believe Drake is right when he claims fever is caused by animalculae." Also in 1836, while still in Cincinnati, Riddell published his paper on *Miasm and Contagion*, regarded as the earliest contribution of its kind ascribing fevers to a presumed organism. Now he found differences at different seasons in the populations of

microorganisms in the Mississippi waters. The life cycle of yellow fever was not known during Riddell's lifetime.

YELLOW FEVER STUDIES AND THE BINOCULAR MICROSCOPE

He was still working at the mint but he also found time to study characteristics of the blood. He likewise examined microscopically *"Le vomite negro"* as the yellow fever was called. He himself contracted yellow fever and recovered to do some of his finest medical work during the famous epidemic of yellow fever in 1853 when he again was appointed to a special committee of investigation. So many were the activities in which Riddell engaged that until a complete bibliography is published one can never be sure that certain ones have not been overlooked.

It was undoubtedly due to his microscopic work that he became interested in improving the instrument. About 1850 he devised a form of microscope that utilized prisms to divide the light and pass it through two tubes each fitted with its own ocular (see Fig. 1). Riddell had been active in organizing the New Orleans Academy of Science and he demonstrated the principles employed in his microscope before the Physico-Medical Society, October 2, 1852. He continued his improvements on the models of instruments and was called on for several New Orleans demonstrations. In July, 1853, he exhibited his invention at a meeting of the American Association for the Advancement of Science. It was not adopted to serious investigation, but Riddell's work paved the way toward improved modern instruments and embodied some new combinations of principles.[22]

His catalog of the *Flora of Louisiana* which he began in 1842 was ten years in being compiled, and as was customary with Riddell included the work of a number of collaborators, in this case, principally that of W. M. Carpenter and Josiah Hale. Although he states in the *New Orleans Medical and Surgical Journal* for May, 1852, that the manuscript was sent to the Smithsonian Institution, it seems to have been lost. As to specimens, Dr. William Penfound of Tulane University lists only six sheets of Riddell specimens. This offers another bit of evidence concerning the feverish impatience of Riddell. When he had recorded an item he was through with it, seemingly giving no thought to any possible use that another might make of the same item.

MONOGRAPH ON THE SILVER DOLLAR

During his period of conducting the operations of the mint he invented an improved method for casting gold and silver for coins. He also published his famous monograph of the silver dollar,[23] which again serves as a means of showing how eager Riddell was to make a record of all facts coming to his attention. The work at the mint kept him constantly in the public eye and when he resigned in 1849, after eleven years of service, he was probably one of the best known citizens of New Orleans. At present he is still well known to numismatists, even though modern collectors know nothing about his other labors and pursuits.

Shortly before the outbreak of the War Between the States, Riddell was made postmaster of New Orleans. When the Confederacy was formed, a new appointment was made but the appointee died before he could assume office. A second appointee refused to serve and Riddell was thus unique in having been appointed before the Confederacy and continuing in office all through the war period. It is thus that his name appears on the stamps issued during the war in the New Orleans postoffice.

The accompanying cut (Fig 2), enlarged, from a stamp in the writer's possession, shows the name of J. L. Riddell above and below on the face of the stamp. Stamp issues serve to commemorate in an additional way the name of this versatile man. He had been so poor in his student days that the price of postage on letters to his mother was a barrier to a dutiful son's letters home. It may well be true that he thought of his own embarrassment in finding postage money when he saw his name for the first time on a two-cent stamp and realized the changes that thirty years in his life had brought.

Perhaps without foundation is the legend that just after the outbreak of the war, he secreted a number of United States stamps by plastering them into the wall of a building in the old French Quarter of New Orleans near the site of the postoffice at that time. He, always fond of recording facts, sent the serial numbers of the sheets to the Postmaster General at Washington. This act was regarded at treasonable to the Confederacy by some of his New Orleans contemporaries. If this was done, the stamps have probably been destroyed by demolition and rebuilding in the older parts of the city.

One final claim to fame rises from the fact that Thomas Nuttall who collected the plants of the Missouri River region named a composite commemoratively *Riddellia tagetina.* Asa Gray added a species to the genus. It was, however, displaced in favor of an earlier named genus, *Psilostrophe D. C.* Perhaps locally better remembered, since a long correspondence in the newspapers ensued about it, is Riddell's interest in aerial navigation. Several of the personal Journal volumes indicate a recurring interest in this field. For Riddell it took the form in public print of a fictitious account of his hero, Orrin Lindsay, who successfully designed an airship and circumnavigated the moon. It is interesting to examine the sketches made by Riddell and to

see how a streamlined model, probably entirely original with him, developed in his imaginative mind.[24]

Just as there are a number of uncertainties about his life so there is more than one account of his death. The obituaries say that his death was not unexpected, as for some time his mind had given away. A different version was given by Mr. Levy, who is a medical student in New Orleans and who is interested in the Riddell biographical material: At the close of the war Riddell made an address in which he indicated that the Confederate point of view had not been sound. He was stopped by protests and boos from the audience. He finally descended from the rostrum indicating that he would prepare an explanation for the newspaper and so left the hall. At the newspaper office where he went to write his explanation he suffered a cerebral hemorrhage and died the following day without having regained consciousness. This rapid exit seems more in keeping with his activities, not all of which can be adequately comprehended, even when his accomplishments as lecturer, teacher, botanist, operator of a mint, inventor of microscopes, medical practitioner and postmaster are recited.

BIBLIOGRAPHY

18. Silliman's *American Journal of Science and Arts*, 2nd Series, XLI (1866), 141.

19. An excellent account of the later part of Riddell's life is to be found in the *Dictionary of American Biography*, XI, 589.

20. See *Ohio State Archaeological and Historical Quarterly*, LIII (1944), 313-38.

21. The history of coinage is a fascinating study in itself. In United States money no dollars were minted between 1806 and 1836. Spanish dollars collected in New Orleans were cut with a cold chisel into "six bits" and "eight bits." The establishment of a branch mint in New Orleans helped relieve the scarcity of coins.

22. For Riddell's microscopes see *New Orleans Monthly Medical Register*, Oct., 1852, Apr., 1853; *New Orleans Medical and Surgical Journal*, Nov., 1853, May, 1854 *American Journal of Science*, Jan., 1853; *Quarterly Journal of Microscopical Science*, *Apr.*, 1853, Jan., 1854, *Proceedings of the American Association for the Advancement of Science*, VII, 1856; Samuel Holmes, "The Isophotal Binocular Microscope," *English Mechanic and World of Science*, July, 1880; Jabez Hogg, *The Microscope* (London 1871), 122.

23. John Leonard Riddell. *A Monograph of the Silver Dollar, Good and Bad* (New Orleans, 1845.)

24. John Leonard Riddell, ed., *Orrin Lindsay's Plan of Aerial Navigation with a Narrative of His Explorations in the Higher Regions of the Atmosphere and His Wonderful Voyage around the Moon* (New Orleans, 1847).

Former Ohioan Appointed

The National Foundation for Infantile Paralysis, Inc., recently announced the appointment of H. M. Weaver as assistant to the medical director of the foundation. A native of Lancaster, Ohio, Dr. Weaver was graduated from the Ohio State University in 1934, and later received his M.Sc. and Ph.D. degrees from the same institution. He has been associated with the Wayne University College of Medicine since 1938 as assistant professor of anatomy.

Heering Asks Immunization To Prevent Possible Smallpox Outbreak

In a recent letter to all Health Commissioners, Dr. Roger E. Heering, director of the State Department of Health, warns of a "considerable outbreak of smallpox on the West coast", the disease having apparently been introduced from the Orient.

In order to prevent an outbreak in Ohio, Dr. Heering suggests that health commissioners and physicians encourage and accomplish the immunization of susceptible elements of the population.

The following notes on immunization accompanied the letter:

1. Smallpox vaccine deteriorates rapidly if stored above freezing. A fresh and potent vaccine insures success.

2. No antiseptic other than ether or acetone should be used to prepare the arm, which should be allowed to dry before the vaccine is applied. The vaccine may otherwise be inactivated.

3. The multiple pressure technique is recommended.

4. The reaction should be read two to three days after vaccination and again eight to ten days after vaccination.

5. Only individuals showing a definite papule and small area of redness at first reading, with subsequent fading, should be regarded as immune. Those with no apparent reaction must be regarded as failures and revaccinated until a "take" is observed.

6. A carelessly performed or interpreted vaccination may be worse than none, if there is created a false sense of security.

Will Aid in Cancer Research

Two members of the Ohio State University faculty have been appointed by the National Research Council to carry on research work of the American Cancer Society.

Laurence H. Snyder, D.Sc., professor of medical genetics, was named as chairman of the panel on human genetics of the Council's division of biology, and Dr. Charles A. Doan, dean of the College of Medicine, was appointed as a member of the panel on clinical physiology on blood and blood-forming organs, a research group under the division of clinical investigation.

On March 6, the University was named by the American Cancer Society to receive one of three monetary grants for cancer research. Effective until June 30, 1947, this grant will support the research of Dr. Madge T. Macklin in the field of human genetics of cancer. Dr. Macklin is a former instructor at the University of Western Ontario, Canada. She will work under the direction of Dr. Snyder.

Dr. N. H. McNerney Directing All Medical Activities of Veterans Administration in Three-State Area; New Rules of Interest to Doctors Announced

DR. NEVILLE H. McNERNEY, formerly of Cleveland, a veteran of World War I and World War II, and a graduate of the Ohio State University College of Medicine, has taken over one of the most important positions of Veterans Administration Branch Office No. 6, with headquarters at 52 S. Starling Street, Columbus, namely, that of Medical Director.



DR. McNERNEY

Dr. McNerney's appointment was announced recently by Ralph H. Stone, Deputy Administrator for the Branch Office which has jurisdiction over all Veterans Administration activities in Ohio, Kentucky, and Michigan.

As Medical Director, Dr. McNerney will be responsible for the proper operation of the Veterans Administration hospitals and National Homes within the three-state area and supervises the care, examination, and treatment of veterans under out-patient programs, in contract hospitals and in clinics.

OTHER APPOINTMENTS MADE

Five other veterans of World War II also have been appointed to staff positions in the Medical Service of the Branch Office. They are Dr. Henry Luidens, Chief of the Neuropsychiatric Division; Dr. Don Marshall, Consultant Ophthalmologist; Miss Ivy M. Wadsworth, Supervisor of Nursing Activities; Mr. Joseph A. Grotenrath, Director of Medical Administrative Services, and Mr. David Anton, Field Supervisor of the Hospital Operations Division.

Dr. McNerney, who served in Europe with the Army Medical Corps in World War I, spent three years during World War II in the United Kingdom on duty with Army station and general hospitals and an Army Hospital Center. He attained the rank of Colonel and was awarded the Bronze Star Medal.

PRACTICED IN CLEVELAND

Making his home in Cleveland between the two wars, Dr. McNerney was surgeon and consulting surgeon for the Nickel Plate Railroad in Cleveland; examiner for the Federal Civil Service of the Post Office Department and the Veterans Administration; consulting examiner for the Brotherhood of Railroad Trainmen; and insurance examiner for the Missouri State Life Insurance and the Security Mutual Life Insurance Companies. He was also chairman of the medical unit of Al Sirat Grotto, a Masonic organization, and industrial physician for several Cleveland firms.

A member of the Cleveland Academy of Medicine, Ohio State Medical Association, and the American Medical Association, Dr. McNerney is a trustee and past monarch of Al Sirat Grotto and a past commander of the Veterans of Foreign Wars, Post 84. He also is a past commander of the American Legion, Kiwanis University Circle, National Guard Officers Association, the Ohio Athletic Club, and the Hoboes of America.

HEADS PSYCHIATRIC SERVICES

Dr. Luidens, who served in the Army Medical Corps for four years at Patterson Field, Dayton,

PROPOSAL OF O.S.M.A. STILL UNDER CONSIDERATION IN WASHINGTON

THE proposal of the Ohio State Medical Association whereby veterans with service-connected disabilities will be able to receive treatment, on authorization, from physicians in private practice on a fee-for-service basis was under consideration by the Central Office of the Veterans Administration, Washington, as this issue of The Journal went to press.

When, and if, the program recommended by the Ohio State Medical Association is approved by the Veterans Administration, complete details will be sent to all members of the Association immediately.

Physicians will be requested to indicate whether or not they desire to participate in the program. Those who do will be placed on the list of fee-designated physicians of the Veterans Administration which will entitle them to render services to veterans in authorized cases and to receive payment from the Veterans Administration for services rendered.

The program even after approval by the Veterans Adiministration will not go into effect until a substantial list of participating physicians has been assembled and basic administrative details have been worked out by Dr. McNerney and his medical and administrative staff. This plan has been agreed upon in order to prevent confusion on the part of veterans as well as physicians.

Ohio, became a Lieutenant Colonel. A graduate of the University of Wisconsin, he received his medical degree from Rush Medical College. He is a member of the American Psychiatric Association, the Columbus Academy of Medicine, the Aeromedical Association and the Ohio State Medical Association.

As Chief of the Neuropsychiatric Division of the Branch Office, Dr. Luidens supervises all neuropsychiatric activities, including clinical psychologists, in Veterans Administration installations within the area. He also is responsible for the selection of properly qualified personnel in the fields of psychiatry, psychology, and neurology.

CONSULTANT OPHTHALMOLOGIST

A graduate of Bowdoin College, Brunswick, Maine, and the University of Michigan, Dr. Marshall attained the rank of Lieutenant Colonel in the Army Medical Corps and served for three years in England, France, and Belgium. Prior to entering the service, Dr. Marshall taught ophthalmology at the University of Michigan and was ophthalmologist at Geisinger Hospital at Danville, Pennsylvania. He also practiced ophthalmology in Michigan and acted as ophthalmologist for the Civil Aeronautics Authority. Affiliated with several ophthalmological and medical associations, he also is a member of the Rotary Club and Alpha Delta Phi and Phi Rho Sigma fraternities.

SUPERVISES NURSING PERSONNEL

Miss Wadsworth, also a Lieutenant Colonel in the Army and recipient of a Bronze Star Medal, spent two years in the United Kingdom as Chief Nurse in several Army hospitals. She was Superintendent of Nurses at Syracuse City Hospital, Syracuse, New York, prior to entering the Army Nurse Corps. In her new capacity, Miss Wadsworth is responsible for the nursing and hospital attendant program in all Veterans Administration clinics and hospitals within the three states. She also supervises educational programs and in-service training courses for nurses, supervisors, and attendants.

Mr. Grotenrath, who served as a Colonel in the Adjutant General's Office in the War Department during World War II, is responsible for the non-professional administration of all Veterans Administration hospitals and homes in the Branch Area.

Mr. Anton, a Captain in the Medical Administrative Corps, saw service in the United Kingdom. His new position also involves lay administration in the various medical installations.

NEW ADMINISTRATIVE RULES CITED

In announcing these appointments, Deputy Administrator Stone also announced that a plan, whereby physicians who treat veterans suffering from malaria or other chronic diseases, characteristically tropical in origin, may be reimbursed by the Veterans Administration, is now in operation in Ohio.

Under this plan, Mr. Stone explained, veterans who have established the service connection of the disease, or whose claim for pension for such a disability is still in the process of adjudication, may be furnished whatever out-patient treatment is indicated by physicians employed either on a salary or fee basis by the Veterans Administration.

In cases where the service connection for malaria has been established, lay evidence is acceptable to establish the frequency of malaria recurrences for a period of one year after the original medical substantiation, or for one year after date of discharge. But when the period involved is more than one year, medical substantiation is essential. This may be obtained by examination disclosing definite effects of the disease, or it may be in the form of written evidence from a physician who has seen the veteran in characteristic chills and fever.

Physicians confronted with such cases may obtain further information by contacting the Veterans Administration.

COLLECT PHONE CALLS AUTHORIZED

Another regulation of interest to physicians also has been announced by Mr. Stone, namely:

The Veterans Administration will accept "collect" telephone calls to the nearest Veterans Administration office or hospital when physicians want to ascertain whether they may be paid by the Veterans Administration for emergency treatments given veterans.

Authority to accept such calls was granted Mr. Stone in a new policy recently released by the Veterans Administration's Central Office in Washington.

This procedure has been approved although such authorization is not needed before the treatment could be started in an emergency, Mr. Stone said. Such payments are made, under existing regulations, only for service-connected disabilities. If it develops that the emergency arose from a non-service-connected disability, then the Veterans Administration will not be responsible for treatments given after it has been determined that the veteran is suffering from a non-service-connected disability.

According to Mr. Stone, Veterans Administration Regulations require that the following conditions be met before reimbursement is possible: It must be an emergency; it must be a service-connected disability; the only exception being an emergency before a determination cited above, or that no Veterans Administration facilities are immediately available in which to treat the veteran.

Hospitals Admissions and Bed Capacity Increased During 1945, Report of Council Shows; Data on Ohio Listed

DURING 1945 one patient was admitted to a hospital in the continental United States every 1.9 seconds and a live baby was born in a hospital every 16 seconds, according to the 25th annual report of the Council on Medical Education and Hospitals of the Americal Medical Association, published in the April 20 issue of *The Journal of the American Medical Association.* The figures reveal that in comparison with 1944 the number of hospital beds has increased from 1,729,945 to 1,738,944, the number of admissions from 16,036,848 to 16,257,402, the number of patient days from 475,607,484 to 512,915,155 and the number of hospital births from 1,919,976 to 1,969,667.

Represented in the report are 6,511 hospitals registered by the American Medical Association, including 1,156 hospitals approved for internships and residencies and 2,625 accredited by the American College of Surgeons as meeting unconditionally its minimum requirements for general standardization. The number of hospitals totals 100 less than reported in 1944.

BED CAPACITY INCREASED

Both governmental and nongovernmental hospitals showed a slight increase in bed capacity last year, the governmental group reporting 1,356,718 or 78 per cent of all beds, the nongovernmental hospitals 382,226 or 22 per cent. The federal hospitals which expanded rapidly during the war had a net loss of 4,751 beds compared with 1944.

In the present survey the general hospitals reported 922,549 beds as compared with 925,818 in 1944. This represents a net decrease of 3,269 whereas the previous year showed an increase of 75,242. With their present facilities the general hospitals have 53 per cent of all beds.

There were 16,257,402 admissions exclusive of outpatients and newborn infants in 1945. This is equivalent to 12.3 per cent of the total population according to the U.S. Census of 1940. Since 1935 the admissions in the hospitals registered by the American Medical Association have more than doubled in number. The greatest annual gain occurred in 1943 when an increase of 2,829,088 was reported. The following year showed an increase of 662,150 while the present survey indicates a net gain of 220,554 in comparison with 1944.

GENERAL HOSPITALS LEAD

The governmental hospitals with 78 per cent of the bed capacity reported 6,399,113 admissions or 39 per cent of the patients admitted in 1945. The nongovernmental hospitals which received 61 per cent had 9,858,289. Both groups showed a substantial increase in hospital admissions in 1944 but in the present survey the governmental hospitals showed a net loss of 146,107 as compared with the previous year.

General hospitals supply the greatest volume of hospital service in the United States. Last year they admitted 15,228,270 patients—93.6 per cent of all admissions—and maintained an average daily patient load of 665,105. In addition they gave care to 1,907,772 newborn infants, 96.8 per cent of all live births reported in the registered hospitals in 1945. The nongovernmental general hospitals had a total of 9,371,874 admissions, the federal general hospitals 3,898,995 and the other governmental general hospitals 1,957,401.

DATA ON MENTAL HOSPITALS

The mental hospitals with 37.7 per cent of all beds had 248,876 admissions or only 1.5 per cent of the total patients admitted in 1945. In comparison with 1944 there was an increased number of mental patients admitted in all nongovernmental groups. The mental hospitals under state, county and municipal control showed a slight decrease, but the federal division reported an increase of 13,147. The total gain in relation to the previous year was 22,483.

The tuberculosis sanatoriums showed a continued decrease in the number of patients admitted as evidenced by the present report of 86,186 admissions as compared with 88,281 in 1944.

The enormous volume of service rendered by hospitals in the United States is likewise reflected in the daily patient load, which averaged 1,405,247 in 1945 exclusive of newborn infants. For the first time also the daily census in general hospitals exceeded the patient load of the mental institutions, the latter reporting an average of 624,349 as compared with 665,105 in the general hospital section. In the previous year the corresponding figures were 618,951 and 570,331 respectively.

For the period represented in this report the registered hospitals in the United States had 13.2 beds per 1,000 population. The actual utilization of hospital beds, however, as determined in relation to the average daily census, was 10.6 beds per 1,000 population.

STATISTICS ON BIRTHS

The governmental hospitals reported 315,149 births in 1945, the church related hospitals 665,153, the other nonprofit associations 793,220 and the proprietary institutions 196,145. The comparative figures for 1944 were 293,424, 652,-761, 773,489. and 200,302 respectively. Last year

the increase in hospital births was 49,691 whereas the previous year showed a decrease of 4,615. In 1942 and 1943, however, increases of 265,659 and 253,992 were reported.

Registered hospitals reported employing 144,724 graduate nurses exclusive of 25,277 private duty nurses during the latter part of 1945. The corresponding figures for 1944 were 125,458 and 23,949.

In connection with the present survey, state accredited schools of nursing reported a student enrolment of 130,909 as compared with 129,879 in 1944 and 110,222 in 1943.

APPROVED OHIO HOSPITALS

The Council registered 234 Ohio hospitals in 1945, three less than in 1944. Their bed capacity was 64,542; bassinets, 3,751, as compared with 63,313 and 3,706 respectively in 1944. Patients admitted numbered 678,849, a slight increase over the 1944 total of 642,530. The average daily census increased from 53,639 in 1944 to 57,471 in 1945.

Ohio hospitals are classified by control as follows: Federal, 11; state, 22; county, 27; city, 19; total governmental, 79; church related, 44; nonprofit associations, 93; total nonprofit organizations, 137; individual and partnership, 10; corporations (profit unrestricted), 8; total proprietary, 18.

Following is the classification of Ohio's registered hospitals by type of service: general, 154; nervous and mental, 23; tuberculosis, 22; maternity, 7; industrial, 1; children's, 3; orthopedic, 3; convalescent and rest, 3; hospital departments of institutions, 11; all others, 7.

TECHNICAL PERSONNEL

Technical personnel employed in Ohio hospitals during 1945 is classified as follows: laboratory technicians, 557 full time and 124 part time; X-ray technicians, 283 full time and 80 part time; dietitians, 332 full time and 20, part time; physical therapists, 133 full time and 18 part time; pharmacists, 122 full time and 26 part time; medical record librarians, 166 full time and 37 part time; medical stenographers, 368 full time and 36 part time; occupational therapists, 82 full time and 10 part time; nurse anesthetists, 146 full time and 9 part time.

APPROVED FOR INTERN TRAINING

The following Ohio hospitals, numbering 44, are approved for internship: City, Peoples and St. Thomas Hospitals, Akron; Aultman and Mercy Hospitals, Canton; Bethesda, Christ, Cincinnati General, Deaconess, Good Samaritan, Jewish and St. Mary's Hospitals, Cincinnati; City, Cleveland Clinic Foundation, Fairview Park, Lutheran, Mt. Sinai, St. Alexis, St. John's, St. Luke's, St. Vincent's Charity, and University Hospitals, Cleveland; Grant, Mt. Carmel, St. Francis, Starling Loving University and White Cross Hospitals, Columbus; Huron Road Hospital, East Cleveland; Good Samaritan, Miami Valley and St. Elizabeth's Hospitals, Dayton; Mercy Hospital, Hamilton; Lakewood, Lakewood; Memorial and St. Rita's Hospitals, Lima; City Hospital, Springfield; Flower, Maumee Valley, Mercy, St. Vincent's, Riverside, Toledo Hospitals, Toledo; Youngstown and St. Elizabeth's Hospitals, Youngstown.

SPECIALIZED TRAINING

All hospitals approved for internship are automatically accredited for mixed residency training. Hospitals in Ohio approved for residencies in specialties number 46. They are: Children's, People's, City and St. Thomas Hospitals, Akron; Aultman and Mercy Hospitals, Canton; Christ, Children's, Cincinnati General, Deaconess, Good Samaritan, Dunham, Jewish, Longview State Hospitals, Cincinnati; City, Cleveland Clinic Foundation, Fairview Park, Glenville, Grace, Lutheran, Mt. Sinai, St. Alexis, St. John's, St. Luke's, St. Vincent's Charity, Woman's, and University Hospitals, Cleveland; Children's, Columbus State, Mount Carmel, Starling Loving University, St. Francis, Franklin County Tuberculosis, and White Cross Hospitals, Columbus; Miami Valley Hospital, Dayton; Huron Road Hospital, East Cleveland; Army Regional Hospital, Fairfield; General Hospital, Mansfield; Massillon State Hospital, Massillon; Maumee Valley, Mercy, Toledo, and St. Vincent's Hospitals, Toledo; Cuyahoga County Tuberculosis Sanitorium, Warrensville; Harding Sanitarium, Worthington; and St. Elizabeth's and Youngstown Hospitals, Youngstown.

SCHOOLS FOR TECHNICIANS

The report of the Council contains a list of 268 schools approved for the training of clinical laboratory technicians and includes the following in Ohio: Children's, City, People's, and St. Thomas Hospitals, Akron; Good Samaritan Hospital, Cincinnati; Mt. Sinai Hospital, Cleveland; University Hospitals, Cleveland; Mt. Carmel Hospital, Columbus; Starling Loving University Hospital, Columbus; Miami Valley Hospital, Dayton; Huron Road Hospital, East Cleveland; City Hospital, Springfield; Mercy Hospital, Toledo; Toledo Hospital, Toledo; St. Vincent's Hospital, Toledo; Youngstown Hospital, Youngstown.

Among the 130 schools approved for X-ray technicians are the following in Ohio; City Hospital, Akron; Cincinnati General Hospital, Cincinnati; City, Mt. Sinai, St. Luke's and University Hospitals, Cleveland; Good Samaritan and Miami Valley Hospitals, Dayton; Huron Road Hospital, East Cleveland; St. Rita's Hospital, Lima; Youngstown Hospital, Youngstown.

Ohio State University, Columbus, is one of 18 schools approved for the training of occupational therapy technicians.

Hearings on Wagner-Murray-Dingell Bill Fail to Attract Much Committee Interest; Names of Those Testifying

HEARINGS on S. 1606, the Wagner-Murray-Dingell Bill, were entering their fourth week before the Senate Committee on Education and Labor, as this issue of *The Journal* went to press.

Described by observers as being "relatively quiet—with a noticeable lack of committee-members present", the proceedings of the committee have attracted little attention since the chairman and co-author of the bill, Senator James E. Murray (D), Montana, took umbrage at the opening session, April 2, when Senator Robert A. Taft (R) Ohio characterized S. 1606 as "the most socialistic measure ever considered by the Congress".

THE ADVOCATES

Following is a list of those who have appeared to date before the committee advocating the passage of the Wagner-Murray-Dingell Bill.

Senator James E. Murray (D), Montana
Senator Robert F. Wagner (D), New York
Congressman John D. Dingell (D), Michigan
Watson B. Miller, Administrator, Federal Security Agency
Dr. J. W. Mountin, medical director, United States Public Health Service, representing Surgeon General Parran
Arthur J. Altmeyer, chairman, Federal Social Security Board
Fiorella H. LaGuardia, ex-mayor of New York, and head of UNRRA
Helen Hall, National Federation of Settlements
Caroline Ware, American Association of University Women
Clark Foreman, president, Southern Conference for Human Welfare
Harold L. Ickes, executive chairman, Independent Citizens Committee of the Arts, Sciences, and Professions
Rev. Francis W. McPeek, chairman, Legislative Committee, Council for Social Action, Congregational-Christian Churches
Rev. Jack R. McMichael, executive secretary, Methodist Federation for Social Service
Dr. Allan M. Butler, associate professor of pediatrics, Harvard Medical School, Boston
Dr. Ernest Boaz, New York City, representing the Physician's Forum
A Mr. Linder, representing the National Lawyers Guild

TAKE NEUTRAL STAND

Joseph W. Fichter, master of the Ohio State Grange and Chairman of the Health Committee of the National Planning Association, appeared before the committee on time apparently allotted to proponents of S. 1606, but he did not speak for the bill. Instead he described a very extensive program that the Planning Association had supported providing for the elimination of tuberculosis and the construction of hospitals.

Statements urging passage of S. 1606 have been issued to the press by Secretary of Commerce Henry Wallace; Mrs. Eleanor Roosevelt; William Green, president of the American Federation of Labor; and by representatives of the Congress of Industrial Organizations. President Truman named a National Health Program as one of his objectives in the address which he made April 12 accepting Hyde Park as a national shrine.

THOSE WHO OPPOSED

At the hearings on April 17-18, opposition to the Wagner-Murray-Dingell bill was expressed by Dr. Roscoe L. Sensenich, South Bend, Ind., chairman of the Board of Trustees of the American Medical Association, and Dr. Victor Johnson, Secretary of the Council on Medical Education and Hospitals of the A.M.A.

Among others who testified in opposition to the measure were: Dr. L. S. Goin, Los Angeles, president of the American College of Radiology and president of California Physicians' Service; Dr. Edward H. Cary, Dallas, Texas, former president of the A.M.A. and present chairman of the Board of Trustees of the National Physicians' Committee; and Dr. Harold T. Low, Pueblo, Colorado, president of the American Association of Physicians and Surgeons.

A representative of the Association of State and Territorial Health Officers told the committee that the Association favored the objectives of the proposed legisuation, but stated that it could not approve in their present form either the Wagner-Murray-Dingell bill or S. 1318, the Pepper Bill, which proposes to extend the E.M.I.C. program to all mothers and children of the United States, regardless of their economic status.

William Logan Martin, representing the American Bar Association, spoke against the Wagner-Murray-Dingell Bill. He pointed out that his organization had not taken an official position on the present bill, but based its stand on similar measures in the past and expressed opposition to its philosophy.

In his appearance before the committee, Dr. Sensenich stated that the proposed National Health bill would: Bring socialized medicine and regimentation of patients and result in inferior

medical care; cost some $4,000,000,000 a year or more and add 1,500,000 persons to government payrolls; fail to produce as good medical care as voluntary prepayment insurance programs which the American Medical Association is now sponsoring through a non-profit corporation.

BLUE CROSS SPOKESMEN OPPOSED

Spokesmen for the Blue Cross voluntary health insurance plans told the members of the Senate Committee on April 22 that Congress should carefully consider the success of voluntary systems before approving the Wagner-Murray-Dingell Bill. The speakers were C. Rufus Rorem, director, and John R. Mannix, chairman of the Blue Cross commission of the American Hospital Association.

It is anticipated that hearings on the bill will continue well into the month of May. There are 18 members of the Senate Committee on Education and Labor. The affirmative vote of 10 of them is necessary to report S. 1606 favorably to the floor of the Senate. Members of the committee are:

Democrats—Senator Murray; Senator Pepper; David I. Walsh, Massachusetts; Elbert D. Thomas, Utah; Allen J. Ellender, Louisiana; Lister Hill, Alabama; Dennis Chavez, New Mexico; James M. Tunnell, Delaware; Joseph F. Guffey, Pennsylvania; Olin D. Johnston, South Carolina; J. W. Fulbright, Arkansas.

Republicans—Senator Taft; George D. Aiken, Vermont; Joseph H. Ball, Minnesota; H. Alexander Smith, New Jersey; Wayne Morse, Oregon; Forrest C. Donnell, Missouri.

Progressive—Robert M. LaFollette, Jr., Wisconsin.

A condensation of the verbatim report of the hearings is being published weekly in *The Journal of the American Medical Association*, beginning with the April 13 issue.

Physician Veterans Organize

Physician veterans of the Academy of Medicine of Toledo and Lucas County have organized an "Association of Medical Officers of World War II", and will attempt to form similar state and national organizations, according to Dr. Harry M. Scott, of Toledo. Dr. A. D. Vogelsang, Toledo, is president of the association, which at last report, numbered 88.

The Cleveland Maternal Health Association will present Walter R. Stokes, M.D., of Washington, D. C., as speaker at its eighteenth Annual Meeting, May 10, at the Hotel Carter, Cleveland. Dr. Stokes has chosen for his subject "New Horizons in Parenthood Planning".

Dr. Olin West Retires as Secretary and General Manager of A. M. A.

The Board of Trustees of the American Medical Association has announced the retirement of Dr. Olin West as secretary-general manager of the Association.

He has been succeeded by Dr. George F. Lull, former deputy Surgeon General of the United States Army Medical Corps, who has been serving as assistant general manager since the first of the year.

Dr. West held that position with the A.M.A. for more than 23 years. He was graduated from Vanderbilt University School of Medicine in 1898. In 1910, after 12 years of practice in Nashville, and 15 years as a member of the faculty of Vanderbilt University, Dr. West became director of the Rockefeller Sanitary Commission and International Health Board in Tennessee.

In 1918 he became secretary and executive officer of the Tennessee State Board of Health, and after four years gave up that position to become field secretary of the A.M.A., in association with Dr. Alexander Craig. Following the death of Dr. Craig, Dr. West was appointed secretary of the Board of Trustees. When Dr. George H. Simmons resigned as Editor and General Manager of the Association in 1924, Dr. West continued in the position of secretary and assumed new duties of general manager.

New Medical Director Appointed By American Red Cross

New medical director for the American Red Cross is Dr. Courtney M. Smith, national headquarters has announced.

Dr. Smith has served with the organization since 1944 as deputy medical director and director of disaster medical service. He succeeds Dr. G. Foard McGinnes, recently appointed vice chairman for health services.

A graduate of the University of Oregon medical school and Yale University, where he obtained the degree of doctor of public health, Dr. Smith entered public health work in Clackamas County and Portland, Oregon, after three years of private practice in Oregon City and Portland. Subsequently he was appointed health officer for the Territorial Department of Health in Alaska, with headquarters in Junea. From April, 1942, until his Red Cross appointment, Dr. Smith was a medical officer in the Office of Civilian Defense.

In May 1945 he was given leave from Red Cross to represent the U. S. Public Health Service with the Army's Strategic Bombing Survey and did a four-months' tour of duty in Germany. A veteran of World War I, Dr. Smith served 26 months with the 63rd Field Artillery in the U. S. and France.

Communities Needing a Physician for General Practice Which Have Requested Help of the Association

DURING the readjustment period, the Ohio State Medical Association has been endeavoring to perform two functions: (1) to assist communities in need of a physician, or another physician, to get medical personnel; (2) to assist physicians seeking locations in finding out where opportunities for practice are available.

During the past several months, physicians and influential citizens of a considerable number of communities have requested the help of the Association.

These areas have been checked and to the best of the knowledge and belief of the Association, they are communities which can use the services of a doctor interested in general practice. Some of them already have a physician but could, it is believed, support another one.

The names of these towns are listed below. Statistical data on them will be supplied on request but it is suggested that interested physicians make personal investigations of as many as possible. In most instances the population of the trading area is much more than the population figure given.

Town	County	Population
Albany	Athens	551
Beach City	Stark	725
Bradner	Wood	836
Buffalo	Guernsey	1,000 in area
Clarksville	Clinton	430
Cleves	Hamilton	1,871
Cumberland	Guernsey	1,500 in area
Cygnet	Wood	569
Dalton	Wayne	774
Damascus	Mahoning	411
East Sparta	Stark	690
Etna	Licking	385
Fayette	Fulton	912
Ft. Jennings	Putnam	326
Glouster	Athens	2,847
Highland	Highland	262
Holland	Lucas	607
Jackson Center	Shelby	566
Lore City	Guernsey	1,200 in area
Lyons	Fulton	464
Mariemont	Hamilton	Suburb of Cincinnati
Mechanicsburg	Champaign	1,653
Metamora	Fulton	490
Mineral City	Tuscarawas	840
Mt. Orab	Brown	589
New Carlisle	Clark	1,237
New Richmond	Clermont	1,767
Oakwood	Paulding	466
Ottoville	Putnam	443
Otway	Scioto	265
Peninsula-Boston Hts.	Summit	900
Pennsville	Morgan	200
Pleasant City	Guernsey	563
Quincy	Logan	536
Rock Camp	Lawrence	58
St. Paris	Champaign	1,308
Seaman	Adams	726
Sinking Spring	Highland	223
Sugar Grove	Fairfield	429
Wayne	Wood	626
West Salem	Wayne	700
Huntsville	Logan	353
Attica	Seneca	780
Louisville	Stark	3,379
Hartville	Stark	1,200
Marlboro	Stark	255
Oak Hill	Jackson	1,619
Jackson	Jackson	6,295
Wellston	Jackson	5,537
Spencerville	Allen	1,623
Rushsylvania	Logan	560
Coldwater	Mercer	2,019
Nevada	Wyandot	741
Nashport	Muskingum	150
Dresden	Muskingum	1,350
Trinway	Muskingum	432
Bergholz	Jefferson	1,122
Carroll	Fairfield	337
Stoutsville	Fairfield	509
Minford	Scioto	200
Croton	Licking	354
Lowell	Washington	528
Lower Salem	Washington	135
Mt. Pleasant	Jefferson	717
Ridgeway	Hardin	375
Port William	Clinton	1,000
Reinersville	Morgan	100
Coal Grove	Lawrence	2,351
Pedro	Lawrence	30
South Point	Lawrence	499
Haverhill	Scioto	91
Pemberton	Shelby	175
Wilkesville	Vinton	221
Leipsic	Putnam	1,525
Berlin Heights	Erie	552
Birmingham	Erie	250
Killbuck	Holmes	716
Vanlue	Hancock	400
Dunkirk	Hardin	922

Obstetrics and Gynecology Board

The general oral and pathology examinations (Part II) of the American Board of Obstetrics and Gynecology, Inc., will be conducted at the Palmer House, Chicago, May 6 through 11. Notice of the exact time of each candidate's examination will be forwarded to him several weeks in advance. Applications for 1947 examinations are being received at the office of the secretary, Dr. Paul Titus, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

New Publications Announced

Two new publications, the *Quarterly Review of Psychiatry and Neurology*, and the *Quarterly Review of Urology* have been announced by the Washington Institute of Medicine, Washington, D.C. Dr. Winfred Overholser, professor of psychiatry, George Washington University School of Medicine, Washington, D.C., is editor-in-chief of the former, and Dr. Hugh J. Jewett, of Johns Hopkins University will edit the latter.

American College of Surgeons

The American College of Surgeons will hold its Thirty-second Clinical Congress at the Waldorf-Astoria Hotel, New York City, September 9 to 13. Plans include demonstrations, scientific sessions, panel discussions, symposia, forums, hospital stadardization conference, medical motion pictures, business meetings, and educational and technical exhibits.

Agency To Establish Standards for Prepaid Medical Care Plans and Coordinate Them Incorporated by A.M.A.

THE Secretary of State of Illinois has issued a certificate of incorporation to Associated Medical Care Plans.

The new corporation is a national nonprofit organization which will include all state and local medical care plans that comply with the minimum standards for medical care approved by the Council on Medical Service and Public Relations of the American Medical Association.

The objects of the new corporation as set out in the articles of incorporation are broad. They embrace a variety of activities, which can be expanded as future experience and developments may indicate. Specifically, the authority granted by the state of Illinois permits the new corporation "to promote establishment and operation of such nonprofit, voluntary medical care plans throughout the United States and Canada as will adequately meet the health needs of the public and preserve and advance scientific medicine and the high quality of medical care rendered by the medical profession of the two countries".

LOCAL AUTONOMY PROVIDED

Significantly, the corporation recognizes that "state and local medical care plans should be autonomous in their operation so that the needs, facilities, resources and practices of their respective areas can be given due consideration, but that the health and welfare of the public is advanced by the coordination through the medium of this corporation of methods, coverages, operations and actuarial data".

The actual activities that are at present contemplated are indicated by the specific duties that the proposed by-laws impose on the commission of the corporation, which, in effect, is the corporation's board of directors.

ACTIVITIES SUMMARIZED

The commission is directed to undertake and promote:

(a) Research and compilation of statistics with special studies of experience and collection and distribution of financial and service data.

(b) Consultation and information services based on contacts with existing and contemplated plans concerning administrative policies and procedures, and the distribution of significant literature and information.

(c) Public education by interpreting the national scope and significance of the medical care plan movement under medical society auspices with publicity methods suitable to the various groups in the public and yet consonant with proper professional practices.

(d) Coordination and reciprocity among plans with reference to transference of subscribers and benefits in the development of national enrolment among large enterprises and authoritative contacts with governmental or national agencies such as Farm Security, welfare and industrial groups.

WORK TO BE ACCOMPLISHED

The necessary details dealing with the manner in which these duties will be performed are matters that will evolve from future meetings of the commission and of members of the corporation. To expedite the initiation of corporate activities, a meeting of the commission was called for April 26 and 27, in Chicago from which will emerge considered operational plans. These will be presented for approval to the first meeting of the members of the corporation, now tentatively to be held in San Francisco the two days immediately preceding the annual session of the American Medical Association in July.

Among the more pressing matters on the agenda of the commission for its April meeting were acceptance of applications for membership and appointment of an executive director to administer the day by day activities of the corporation. Plans, at least temporarily, call for the establishment of an office, with necessary administrative and clerical staff, in the headquarters building of the American Medical Association, thus facilitating coordination of the activities of the new corporation and of the Council on Medical Service and Public Relations of the American Medical Association.

TEMPORARY OFFICIALS

The following men are serving as indicated on an interim basis until the membership can elect officers at the corporation's first annual meeting:

President—F. E. Feierabend, M.D., of Surgical Care, Inc., Kansas City.

Vice-President—William M. Bowman, of the California Physicians' Service, San Francisco.

Treasurer—Norman M. Scott, M.D., of the Medical Service Plan of New Jersey, Clinton.

Secretary—Jay C. Ketchum, of the Michigan Medical Service, Detroit.

Commissioners—Willard C. Marshall, Oregon Physicians' Service, Portland; Edwin M. Kingery, Iowa Medical Service, Des Moines; Arthur J. Offerman, M.D., Nebraska Medical Service, Omaha; L. Howard Schriver, M.D., Ohio Medical Indemnity, Cincinnati; Lester H. Perry, Medical Service Association of Pennsylvania, Harrisburg; Herbert H. Bauckus, M.D., Council Medical Society of State of New York, Buffalo; Raymond L. Zech, M.D., Seattle, Council on

Medical Service and Public Relations of the American Medical Association; A. W. Adson, M.D., Rochester, Minn., Council on Medical Service and Public Relations of the A.M.A., and Edward J. McCormick, M.D., Toledo, Council on Medical Service and Public Relations of the A.M.A.

KETCHUM TO AID A.M.A.

Mr. Ketchum also has been appointed Director of the newly created Division on Prepayment Medical Care, a branch of the Council on Medical Service and Public Relations of the A.M.A.

This appointment, announced by the Executive Committee of the Board of Trustees, became effective March 15.

Mr. Ketchum will serve on a part-time basis according to arrangements made with Michigan Medical Service. His principal duties for the present will be to co-ordinate existing medical care plans in states and to aid states in establishing their own prepayment medical care plans. Mr. Ketchum still retains his position with the Michigan Medical Service.

Monograph on Industrial Health Hazards Available

The Ohio Department of Health has published a monograph entitled "Legal Requirements for the Prevention and Control of Industrial Public Health Hazards". Prepared by the Division of Industrial Hygiene, the booklet lists the laws of Ohio concerning employment which in whole or in part are administered by the Ohio Department of Health and the regulations of the Ohio Sanitary Code pertaining to industrial health hazards.

Statutes included are those relating to the reporting of occupational diseases; those relating to the manufacture of lead and prescribing the responsibilities of employer and employe; and the authority of the Department to extend the list of employments prohibited to minors.

Regulations included are those relating to the use of mercurial carrot in hatters' fur, adopted Oct. 18, 1941; and for the recognition, prevention, and control of diseases resulting from exposure to toxic dusts, fumes, mists, vapors, and gases, adopted Feb. 16, 1946, effective Jan. 1, 1947.

Every physician who has industrial cases should have a copy of this monograph. It may be obtained by addressing the Division of Industrial Hygiene, Ohio Department of Health, 65 South Front St., Columbus 15.

The Cleveland Academy of Medicine has undertaken to raise $1,000,000 as the contribution of the medical profession to the $9,250,000 Greater Cleveland Hospital Fund, according to an announcement of Dr. Howard Dittrick, chairman of the Academy's medical advisory committee.

COMING MEETINGS

Ohio State Medical Association, Columbus, May 7-9.

American Medical Association, San Francisco, July 1-5.

American Association of the History of Medicine, Atlantic City, May 26-27.

American Association of Plastic Surgeons, Toronto, Canada, June 3-4.

American Association for the Study of Goiter, Chicago, June 20-22.

American Association for Thoracic Surgery, Detroit, May 29-31.

American Broncho-Esophagological Association, Chicago, May 31.

American College of Chest Physicians, San Francisco, June 29-July 2.

American College of Physicians, Philadelphia, May 13-17.

American College of Surgeons, New York City, Sept. 9-13.

American Congress of Physical Medicine, New York City, Sept. 4-7.

American Dietetic Association, Cincinnati, Oct. 14-18.

American Federation for Clinical Research, Atlantic City, May 28.

American Gastro-Enterological Association, Atlantic City, May 24-25.

American Laryngological Association, Chicago, May 29-30.

American Laryngological, Rhinological and Otological Society, Chicago, May 27-28.

American Otological Society, Chicago, May 31-June 1.

American Pediatric Society, Skytop, Pa., May 1-3.

American Public Health Association, Cleveland, week of Nov. 11.

American Roentgen Ray Society, Cincinnati, Sept. 17-20.

American Society for Research in Psychosomatic Problems, New York, May 11-12.

American Urological Association, Cincinnati, July 22-25.

Association of American Physicians, Atlantic City, May 28-29.

Interstate Postgraduate Medical Association, Cleveland, Oct. 15-18.

Ohio Public Health Association, Columbus, May 23.

Society of American Bacteriologists, Detroit, May 21-24.

Special Train to 'Frisco a Sellout; However, File Your Application as Additional Accommodations May Be Secured

AS THIS issue of The Journal went to press, the Ohio State Medical Association Special Train to San Francisco project was a complete sellout, with a waiting list of applicants.

However, those definitely interested in joining the Special Train Party should not hesitate to get their application on file with Executive Secretary Nelson.

There may be cancellations. Also, efforts are being made to secure additional hotel space at Los Angeles and Banff. These are the two bottle-necks.

If additonal hotel space in those cities can be obtained, the size of the Special Train Party will be enlarged.

Future applications will be numbered and filed in the order received and will be filled in that order in event of cancellations or the securing of additional hotel accommodations.

Those who have made applications or who are planning to do so, on the chance that additional space will be available, should write immediately to San Francisco for hotel space in the A.M.A. convention city. Hotel applications should be addressed to Dr. M. Lawrence Montgomery, chairman, Subcommittee on Hotels, 200 Civic Auditorium, San Francisco. Mention the fact that you are coming, or plan to come, on the Ohio State Medical Association Special Train.

Definite data on rates is expected momentarily from The Pullman Co. As soon as this data is available, quotations and other essential information will be mailed to all filing applications.

WHAT TRIP WILL INCLUDE

The Special Train Trip will be an all-expense feature with certain exceptions.

The all-expense cost **WILL INCLUDE** round-trip railroad and Pullman fares from Chicago and back to Chicago; hotel charges at Los Angeles and Banff; costs of sightseeing at Denver Mountain Parks, Salt Lake City, Portland, Vancouver, Lake Louise and Banff; tips; transfer charges; and costs of meals en route to San Francisco and return to Chicago, with the exception of meals in Los Angeles.

The all-expense costs **DOES NOT** include railroad and Pullman fares from home city to Chicago and from Chicago to home city; costs of hotel, meals and sightseeing in San Francisco during the A.M.A. meeting; nor meals and sightseeing in Los Angeles.

STARTING TIME; DATE OF RETURN

Under present plans, the Ohio State Medical Special will leave Chicago on June 25. It will arrive in San Francisco, July 1; It will leave San Francisco, July 5. It will return to Chicago on July 12.

ITINERARY OF THE SPECIAL TRAIN

TUESDAY, JUNE 25

Leave Chicago.

WEDNESDAY, JUNE 26

Arrive Denver.

Sightseeing trip through Denver Mountain Parks.

Leave Denver.

THURSDAY, JUNE 27

Arrive Salt Lake City.

Sightseeing trip of city, including Mormon Temple, etc.

Leave Salt Lake City.

FRIDAY, JUNE 28

Arrive Los Angeles.

Hotel accommodations will be provided for the stay of two and one-half days and two nights in Los Angeles. No sightseeing will be arranged as there are so many special sightseeing features offered by Los Angeles that a planned schedule would not be practical. The costs of meals and sightseeing in Los Angeles are not included in the all-expense rate.

SUNDAY, JUNE 30

Leave Los Angeles.

MONDAY, JULY 1

Arrive San Francisco.

The party will spend five days in San Francisco for the A.M.A. meeting and seeing the wonders of the Golden Gate City. No expenses while in San Francisco are included in the all-expense rate. Hotel reservations must be made direct by all members of the party.

FRIDAY, JULY 5

Leave San Francisco

(Continued on next page)

SATURDAY, JULY 6

Arrive Portland.

Sightseeing trip along the gorgeous Columbia River with its falls, dams and scenic wonders.

Leave Portland.

SUNDAY, JULY 7

Arrive Vancouver, British Columbia.

Sightseeing trip of this typical Canadian metropolis.

Leave Vancouver.

MONDAY, JULY 8

En route on train through Canadian Rockies.
Arrive Banff.

TUESDAY, JULY 9

Sightseeing at Beautiful Lake Louise.

WEDNESDAY, JULY 10

All Day at Banff.

Since a wide variety of recreation such as golf, tennis, fishing, swimming, trail riding, hiking, etc., is available at this famous Canadian resort, no special schedule has been arranged for the day.

Leave Banff.

THURSDAY, JULY 11

En route through Canada.

FRIDAY, JULY 12

Arrive St. Paul.

Leave St. Paul.

Arrive Chicago.

Arrival in Chicago will be in time for members of the party to catch night trains out of Chicago for home cities.

The foregoing schedule has been tentatively arranged and will be carried out unless unforeseen circumstances necessitate modifications.

APPROXIMATE COSTS

Because a few details have not as yet been complete, it is impossible to quote exact figures on the all-expense feature costs at this time.

However, a close estimate indicates that the all-expense tour cost from Chicago and return to Chicago will be approximately $298.45 for one person in a lower berth.

This is the base cost. The cost of accommodations in rooms and compartments on the train will be proportionately higher. These rates can be quoted when types of accommodations desired are known.

The $298.45 quotation does not include railroad and Pullman fares from home city to Chicago and from Chicago to home city. It does not include meals and sightseeing in Los Angeles. It does not include expenses in San Francisco.

EQUIPMENT, MISCELLANEOUS INFORMATION

First-class, standard, air-conditioned railroad and Pullman equipment has been promised by the railroads.

First-class hotel accommodations will be provided in Los Angeles and at Banff.

A liberal allowance has been made for meals, so they will be of the best.

Excellent equipment for the sightseeing trips has been promised.

REPORT ON ANNUAL MEETING TO BE PUBLISHED IN JUNE ISSUE

Complete details regarding the Centennial Anniversary Meeting of the Ohio State Medical Association, including the minutes of the sessions of the House of Delegates, to be held in Columbus, May 7, 8, and 9, will be published in the June issue of The Journal.

Association Wants House Officer

The International Grenfell Association announces an opening for a house officer in June, for one year, in the association's hospital at St. Anthony, North Newfoundland. This 120-bed institution serves the entire northern end of the island, where the coasts are icebound for several months each year. Applicants should be under 30, male or female, unmarried, and should have completed internship. The work consists of assisting the resident physician, and includes occasional trips to the outports.

The salary is $1,000 for the year; maintenance and travel provided by the association. Application forms and information may be obtained from the association at 156 Fifth Avenue, New York 11.

A.P.H.A. To Meet in Cleveland

The executive board of the American Public Health Association has announced the 74th Annual Meeting of the Association to be held in Cleveland, the week of November 11, 1946. Dr. Harold J. Knapp, Cleveland's Health Commissioner, has been appointed the Chairman of the local committee.

George W. Cooley, executive secretary of the Academy of Medicine of Toledo for eight years, has resigned to join the staff of The Council on Medical Service and Public Relations of the American Medical Association. His successor is Robert W. Elwell, a graduate of the University of Toledo, who has specialized in personnel work for several years.

Examinations for License in Ohio Taken by 259 Medical School Graduates; List of Questions Asked by Board

LICENSES to practice medicine and surgery in Ohio were sought by 259 medical school graduates at the examinations of the State Medical Board, held in Columbus, March 19-22.

Seventeen applicants were examined in osteopathic medicine and surgery. In addition, 21 osteopaths, previously licensed in Ohio, sought licensure under the provisions of Sub. H. B. 112, which has been in effect since July 30, 1943. Seven osteopaths took an oral examination for endorsement of license.

Examinations for certificates of limited practice were taken by 8 chiropractors, 20 mechanotherapists, 7 chiropodists, 29 masseurs, and 7 cosmetic therapists.

Results of the examinations will be announced by the Board at a meeting to be held in Columbus, May 7.

Following are the written questions asked those who were examined for licenses to practice medicine and surgery:

ANATOMY

1. Give the relations of the cervical portion of the trachea.
2. Describe the shoulder joint with emphasis on the structures that strengthen it.
3. Describe the menisci (semilunar cartilages) of the knee.
4. Describe the lateral wall of the nasal cavity with emphasis on the openings in it.
5. Differentiate between upper motor neurones and lower motor neurones. What are the effects of destructive lesions of each of these types of neurones on (a) the superficial reflexes; (b) the deep reflexes?

CHEMISTRY

1. Discuss the qualitative and quantitative determination of free HCL in gastric content.
2. State the general properties and mention the compound elements of protein.
3. What are esters? How are they formed?
4. What is a hormone? Give one as example and discuss function of chemical nature.
5. Describe the Van den Bergh Test and state indications for its use.

PHYSIOLOGY

1. Trace a morsel of food through the human digestive tract, naming and giving the organ of origin and the main action of each successive fluid, juice or secretion involved as it appears.
2. Give an approximate table of time for eruption of first and second teeth.
3. Define: (a) vitreous body; (b) binocular vision; (c) vital capacity; (d) opsonic index; (e) lymph.
4. What is the function of: (a) ampulla of Vater; (b) seminal vesicles; (c) periosteum; (d) vernix caseosa; (e) optic chiasm.
5. What is meant by "Summation of Stimuli"?
6. What is the function of the portal circulation?
7. Give a schematic outline of the excretion of urine.
8. Discuss the physiological effects of destruction of brain tissue along the fissure of Rolando.
9. Describe the changes undergone by a muscle when it goes into rigor mortis. How soon after death does this occur?
10. Describe the application of the principles of conditioned reflex to education and normal development.

PATHOLOGY

1. Discuss the pathology of syphilitic aortitis and two probable sequels.
2. What is the common non-malignant tumor of the uterus and discuss its causal relation to menorrhagia and metrorrhagia.
3. Give the pathology of three conditions which may cause hematuria.
4. Discuss the pathology resulting from essential hypertension and the relation of such pathology to two ways of fatal termination.
5. Discuss the pathology of virus pneumonia in contrast with that of lobar pneumonia.
6. Describe the pathology of a common type of gastric carcinoma and the accompanying disturbances in gastric function.
7. Describe the pathologic picture of carcinoma of the head of the pancreas and the disturbances in function which may follow in the pancreas and neighboring organs.
8. Give the pathologic findings, primary and secondary, in pernicious anemia.
9. Give the pathologic findings in the sputum in (a) lobar pneumonia; (b) advanced pulmonary tuberculosis; (c) asthma; (d) congestive heart failure.
10. Give the etiology of amebic dysentery; describe the pathology of the primary area affected and that of a possible secondary lesion. Give the technique of obtaining a specimen and demonstrating the organism. Outline the measures of preventing infection.

DIAGNOSIS

1. Give signs and symptoms of cardio-spasm and duodenal ulcer.
2. Give signs and symptoms of manifest progressive arteriosclerosis of arteries of brain.
3. Give symptoms of cancer of the pancreas (body).
4. Differentiate between intercostal neuritis and pleurisy.
5. Name three cardinal signs of multiple sclerosis and give usual age of patient.
6. Differentiate malignancy of bones of sacrum, and ilium and dislocated intervertebral disc.
7. Differentiate acute epididymitis, right inguinal hernia and stone coming through right ureter.
8. Are all hypertensives arteriosclerotic and give findings in nephrosclerosis—blood findings and urine.
9. What is Broadbent's sign and in what condition is it found?
10. Differentiate Bell's Erb's and palsy caused by hemorrhage in internal capsule.

PREVENTIVE MEDICINE

1. Discuss trichinosis in the human, giving cause, means of transmission, incidence, mortality rate and method of control.
2. Name five diseases that are regarded as hereditary.
3. Outline an adequate immunization program for infants.
4. How are milk-borne epidemics characterized and how prevented?
5. When should quarantine be terminated in smallpox; diphtheria; scarlet fever?

MATERIA MEDICA AND THERAPEUTICS

1. Define (a) Oxford unit; (b) Cat unit.
2. Give dosage and mode of action in malaria of atabrine, plasmoquin and quinine.
3. (a) Name two conditions in which plasma is preferred to whole blood.
   (b) Name two conditions in which normal saline is preferred to whole blood or plasma.
4. Outline treatment of patient with incipient or minimal pulmonary tuberculosis.
5. Give signs and symptoms of digitalis intoxication.
6. Give treatment for barbiturate poisoning.
7. Name the ten drugs you most frequently employ and give dose of each.
8. Give the principal alkaloid of:
   (a) Belladonna
   (b) Opium
   (c) Nux vomica
   (d) Hyoscyamus
9. Outline treatment of primary syphilis.
10. (a) Name two respiratory stimulants.
    (b) Give dosage and method of administration.

MATERIA MEDICA AND THERAPEUTICS
(Homeopathic)

1. Compare the cough indicating the use of aconite: bryonia; spongia.
2. Give three remedies for use in croup and give the guiding symptoms to differentiate their use.

(Continued on next page)

3. Compare the fever picture presented by baptisia, belladonna and rhus tox.
4. Present the symptoms that would indicate the use of calcarea carb. in infancy.
5. Compare the indications for bryonia, eupatorium and gelsemium in influenza.
6. Give the nasal symptoms and modalities indicating pulsatilla Nig.
7. Name and give indications for each of five remedies frequently called for in treatment of "The Common Cold".
8. Give the differential indications for three remedies in scarlet fever.
9. Give the gastric symptoms of nux vomica.
10. How do you potentize common marble?

BACTERIOLOGY

1. Give the technique of the Gram Stain. For what purpose is it used and give five examples of Gram positive and Gram negative organisms.
2. Give a classification of micro-organisms according to (a) form; (b) manner of grouping; (c) action in regard to oxygen and (d) disease or non-producing action.
3. Define immunity; how is it produced? Give types and three examples of how it is employed in prevention of disease.
4. How do viruses differ in size, morphology and cultural ability from ordinary organisms? Name five diseases presumably caused by viruses.
5. How would you differentiate the typhoid bacillus from the para typhoid? The B. coli and the B. dysenteriae?

OBSTETRICS AND GYNECOLOGY

1. Discuss the etiology and treatment of postpartum hemorrhage.
2. Give symptoms and treatment of threatened rupture of the uterus.
3. Discuss the advantages and disadvantages of continuous caudal anesthesia to produce painless labor.
4. Discuss management of a face presentation.
5. Give the predisposing causes, diagnosis and treatment of extra-uterine pregnancy.

SURGERY

1. Discuss briefly fractures in the region of the ankle joint.
2. Discuss the causes, symptoms, and treatment of a rather marked condition of varicose veins of the leg in a female of forty years of age.
3. Give the surgical management of a lacerated wound of the knuckle sustained by a man striking his opponent in the mouth. What are the potential dangers of this wound?
4. Give the symptoms, signs, and pathology of inflammation of Meckels' diverticulum, and discuss briefly the treatment.
5. Describe causes, prevention and management of lesions of the extremities produced by exposure to cold. Emphasize their military significance.

PRACTICE

1. Give definition, etiology, clinical features and diagnosis of epidemic hepatitis.
2. Give two causes of syncope and the mechanisms involved.
3. (a) Classify the anemias.
   (b) Name the factors producing an iron deficiency anemia.
4. (a) Give the stages in the life cycle of plasmodium vivax.
   (b) To what factors are attributed the greater virulence of plasmodium falciparium
5. Give etiology, symptoms and diagnosis of amoebiasis.

SPECIALTIES

1. What measures would you take to control Poliomyelitis?
2. Give symptoms, dangers and treatment of suppurative otitis media.
3. Discuss the differential diagnosis between chickenpox and smallpox.
4. Define or describe glaucoma, strabismus, blind spot, residual air, dacrocystitis.
5. Discuss the care of the premature infant.

The Academy of Medicine of Cleveland has announced a plan to establish cancer detection clinics in Greater Cleveland hospitals interested in providing such service.

Medical ASPT To Be Terminated June 1; Disposal of Men Outlined

The medical Army Specialized Training Program will be terminated by June 1, 1946, according to a War Department announcement.

Enlisted men assigned to ASTP for medical training who are scheduled to graduate from medical school before July 1, 1946, will not be separated from the Army regardless of age, length of service, critical score, or by virtue of having three or more children under eighteen years of age. They will not be permitted to enlist in the Regular Army. They may be separated under existing regulations pertaining to discharge of enlisted men because of undue hardship or because of importance to National health, safety, or interest. They will not be separated for any other reason except as individually authorized by the War Department.

The order makes the following provisions for enlisted men assigned to ASTP for medical training who are not scheduled to graduate from medical school prior to July 1, 1946:

Those enlisted men who meet current War Department criteria for separation may be discharged. Those enlisted men who are eligible for discharge under April 30 or June 30 criteria and who do not plan to continue their medical studies may be reassigned within the service command until the date of their discharge if their services are needed. If their services are not needed, they will be discharged.

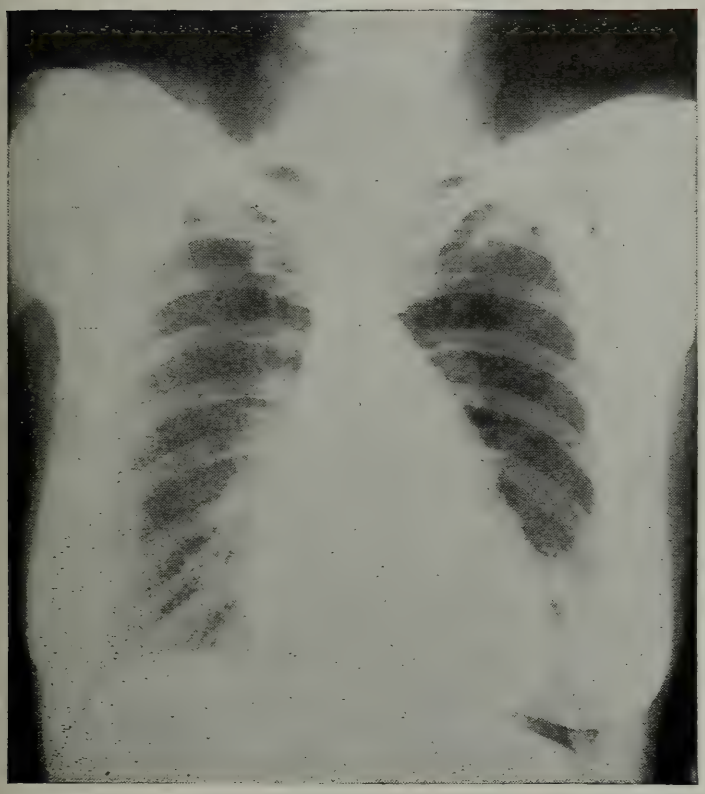
Those enlisted men who do not meet War Department criteria for separation, who do not plan to continue their medical studies, or are not acceptable at an accredited medical school will be transferred to Brooke Army Medical Center, Fort Sam Houston, Texas.

Those enlisted men who are not eligible for separation, who signify their intention to continue their medical studies, and are acceptable at an accredited medical school will be released from active Federal Service and transferred to the Enlisted Reserve Corps. These men will furnish a certificate from the dean or other similar official of a medical school approved by the Council of Medical Education and Hospitals of the American Medical Association.

Provision is made that these men must sign a statement requesting transfer to the Enlisted Reserve Corps and agreeing to certain conditions pertaining to termination of enrollment or requests for transfers between medical institutions.

Columbus—Dr. Ollie M. Goodloe, Washington, D. C., has been named city health commissioner to replace Dr. Nelson C. Dysart who resigned effective April 1, according to Dr. Hamilton G. Robinson, president of the Board of Health.

congestive heart failure



The de-edematizing action of Searle Aminophyllin decreases the cardiac burden, permitting the heart muscle to function more efficiently.

Searle Aminophyllin produces diuresis whether administered orally or parenterally, and thus has a field of usefulness covering emergencies and chronic congestive cardiac failure.

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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

VETERANS' INQUIRY DEPARTMENT

Ohio Openings and Locations Sought by Returning Medical Officers; Opportunities Available Listed

THE purpose of this department is to provide space without cost to Ohio veteran physicians for the publication of inquiries they may wish to make concerning an assistantship or residency, a partnership or space in an office, locations and purchase of a practice, purchase of equipment, etc.

The new feature also offers an opportunity for physicians who desire to dispose of their practice or institutions and agencies needing staff physicians to publicize this information for the benefit of service men.

The feature will appear monthly as long as there seems to be a need for it. The regulations governing it are: (1) The veteran submitting the inquiry must be an Ohio physician, i.e., one who was in practice in Ohio when he entered the service or was a native of Ohio but still in training when he entered in the service. (2) Inquiries should not exceed 35 words. (3) Copy must be submitted by the 20th day of the month preceding date of publication. (4) Unless otherwise specified, each inquiry will be carried in two consecutive issues of *The Journal* but no oftener. (5) *The Journal* reserves the right to reject or edit copy submitted; also, to eliminate the new department when and if conditions warrant. (6) Inquiries should be accompanied by full name, forwarding address and identifying data.

OPPORTUNITIES SOUGHT

SURGICAL RESIDENCY WANTED: By returning medical officer, age 46, with 15 years general practice and surgery; three years assistantship to general surgeon; 20 months in general surgery in Army overseas. Available after January 1. V.I.D. No. 10, care of Ohio State Medical Journal.

PRACTICE WANTED: Veteran will buy practice of retiring or deceased physician, small city preferred. Ten years' practice before entering service. V.I.D. No. 11, care of Ohio State Medical Journal.

INDUSTRIAL OR INSURANCE POSITION WANTED: By discharged Army medical officer. Ten years in general practice. Over three years in service, mostly spent as administrative head of installation doing large number of physical examinations. Age 44. V.I.D. No. 12, care of Ohio State Medical Journal.

OPHTHALMOLOGY TRAINING SOUGHT: Training in ophthalmology through residency or assistantship wanted by discharged Army medical officer; ten months' eye work in Army; capable refractionist. Age 34. Graduate of Ohio State University College of Medicine. V.I.D. No. 13, care of Ohio State Medical Journal.

TRAINING IN OTOLARYNGOLOGY: Discharged Naval flight surgeon, with 62 months of military service, age 41, graduate of Ohio State University, desires post-graduate training in otolaryngology and refraction by means of residency or assistantship. V.I.D. No. 14, care of Ohio State Medical Journal.

ASSOCIATION SOUGHT: Discharged Navy medical officer, age 33, thorough training in internal medicine, especially cardiology, graduate of University of Cincinnati, desires association with established internist or group clinic. Will locate in small town in need of internist. Member of Cincinnati Academy of Medicine. V.I.D. No. 15, care of Ohio State Medical Journal.

INTERNIST SEEKS OPENING: Internist, with two and one-half years clinical training, completing American Board of Internal Medicine examinations, age 33, licensed in Ohio, desires association with group or well-established internist. Available after April 1, 1946. V.I.D. No. 16, care of Ohio State Medical Journal.

WANTS SURGICAL RESIDENCY: Veteran medical officer, age 36, with year's internship, year of general residency, two years of general practice and 57 months service in Army as battalion surgeon and 25 months with orthopedic section of general hospital, desires approved residency in general surgery. V.I.D. No. 17, care of Ohio State Medical Journal.

ASSOCIATE PRACTICE SOUGHT: Internist, age 31, graduate of University of Cincinnati College of Medicine, 1938, four years hospital training, including one year cardiac fellowship, eligible for certification by American board, desires association with internist or group. Available immediately. V.I.D. No. 18, care of Ohio State Medical Journal.

PRACTICE WANTED: Obstetrician and gynecologist, discharged medical officer, age 38, desires obstetrical and gynecological practice or association; eligible for American board. V.I.D. No. 19, care of Ohio State Medical Journal.

RESIDENCY DESIRED: A gynecological or surgical residency wanted by returning medical officer, age 42, with three and one-half years hospital training and 10 years general practice; available in March. V.I.D. No. 20, care of Ohio State Medical Journal.

ASSISTANTSHIP WANTED: Discharged Army medical officer desires assistantship with busy general practitioner. Graduate of Northwestern Medical School, 1940; one year rotating internship, Cincinnati General Hospital; special training and degrees in chemistry, physiology and gastroenterology; age 32; single. V.I.D. No. 21, care of Ohio State Medical Journal.

OPPORTUNITIES OFFERED

CLINIC STAFF OPENING: Opening for young man interested in general practice on staff of group clinic. Compensation first few months on salary basis; thereafter on percentage basis. All equipment furnished by clinic. L.A.C. care of Ohio State Medical Journal.

OFFICE AND HOME FOR SALE: Physician's home and office in community of 4,500 near Cleveland, centrally located, completely redecorated, for sale. Equipment, instruments, and some drugs also for sale. Owner remaining in military service. MED in care of Ohio State Medical Journal.

PRACTICE AVAILABLE: Practice in Valley City, Medina County, 20 miles from Cleveland, in heart of thriving farming and dairy community, available. Physician who located there during war emergency, desires to return to special practice in city. House, with combined office, available any time. Contact Dr. F. C. Reutter, Valley City, Ohio.

PART-TIME INDUSTRIAL PRACTICE: Good opening for physician interested in part-time industrial practice, physical examinations, and emergencies. Columbus industrial firm. Write C.W.C., care of the Ohio State Medical Journal.

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Clinical as well as laboratory tests have shown PHILIP MORRIS to be definitely and measurably less irritating to the sensitive tissues of the nose and throat. May we send you reprints of the studies?



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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

GENERAL PRACTICE: Opportunity for general practice in town of 1,000 in Northwestern Ohio. Only one other physician. Home and office space available. One of Ohio's best agricultural areas and good marketing section. Write W. L. G., care of Ohio State Medical Journal.

GENERAL PRACTICE AVAILABLE: Physician wishing to retire wants to dispose of practice to returning veteran. Located in Wilmington, Clinton County, excellent farming community; good roads. Equipment includes modern furniture, large supply of drugs, supplies and instruments and library. Office rent reasonable and equipment and practice priced to sell immediately. R. H. Vance, M.D., 114 East Locust Street, Wilmington.

INDUSTRIAL POSITION: Desirable position on medical staff of large rubber company; good salary. F.T.R., care of Ohio State Medical Journal.

INDUSTRIAL COMMISSION: Openings available in Medical Section, Ohio Industrial Commission. Consult Dr. Robert André, chief supervisor, Medical Section, State Office Bldg., Columbus.

STATE HOSPITAL STAFF OPENINGS: Staff physicians for various institutions serving the mentally ill, mentally defective and epileptic needed. Physicians who have had some psychiatric training or experience preferred but can offer positions to doctors who may be interested in becoming acquainted with the specialty. Two positions of special importance now open are: Superintendency, Youngstown Receiving Hospital (especially attractive for young physician with residency in psychiatry) and Clinical Directorship, Gallipolis State Institute (fine opportunity for man who has had neuropsychiatric training to become acquainted with those neurological conditions that cause epilepsy in addition to a chance to be a specialist in the field of true epilepsy). Consult Dr. Frank F. Tallman, Ohio Commissioner of Mental Hygiene, State Departments Building, Columbus 15.

PUBLIC HEALTH OFFICERS NEEDED: Several counties in Ohio in need of full-time health commissioners. Those with training and experience, or interested in public health work, may obtain complete details from Dr. Roger Heering, Ohio Director of Health, State Departments Building, Columbus 15.

PRACTICE FOR SALE: Active practice in a community of 3,000, North Central Ohio. Large amount of industrial work in addition to regular practice. Equipment includes new X-ray, diathermy, modern furniture, drugs and supplies. No real estate for sale. Moderate rent. Estimated price $7,500, cash or terms. Will introduce for a short time. Write R.J.S., care of Ohio State Medical Journal.

TUBERCULOSIS HOSPITAL OPENING: Resident physician needed in this institution doing intensive collapse therapy, including surgery. Good opening for man who desires to enter this field of medicine. District Tuberculosis Hospital, Lima; H. H. Brueckner, M.D., superintendent.

VETERANS ADMINISTRATION: Openings for physicians as members of rating boards for either full time or part time duty. Basic salary $4300.00 per annum, with additional compensation for overtime. Contact nearest V.A. office for particulars.

PRACTICE AVAILABLE: General practice at Friendship, Scioto County; seven miles from Portsmouth, which has two hospitals; population of area about 8,000; centralized elementary school; within six miles of High School; two Protestant churches; combined residence and office, with four-acre plot, available for sale or rent; no other physician in community. G.F.J., care of Ohio State Medical Journal.

FULL-TIME RESIDENT PHYSICIAN NEEDED: At Homeplace, Perry County, Kentucky, operated by E. O. Robinson Mountain Fund as educational center for mountain people. Graduate nurse; clinic building being planned; affiliation with medical center in Cincinnati for consultation and specialized services; salary $5,000 per year, with home and transportation furnished. Write Dr. Howard P. Fischbach, 1122 Carew Tower, Cincinnati 2, Ohio.

PRACTICE AND HOME FOR SALE: Active practice established 10 years in town of 2000 with local post office serving 8000. Brick and stone home with modern interior. Has suite of rooms for office. All modern office equipment with stock of drugs and X-ray, diathermy, ultraviolet. Seeing more than 20 patients per day. Physician urgently needed. Forced by service-connected disability to retire from general practice. All is offered to a veteran for price of real estate alone. Liberal terms; can pay for all in three years from earnings. M. R. Wedemeyer, M.D., Oak Hill, Ohio.

Drs. Zollinger and Morton Join O.S.U. Medical Staff

Appointments of Dr. Robert M. Zollinger as professor of clinical surgery and Dr. Joseph L. Morton as assistant professor of roentgenology in the department of surgery in Ohio State University's College of Medicine have been announced by Dr. Charles A. Doan, dean of the college.

Both men are Ohio State alumni, Dr. Morton having received his medical degree in 1936; Dr. Zollinger the bachelor of science in 1925 and the doctor of medicine in 1927. Both have recently returned from Army service.

Dr. Zollinger entered the military service in 1942 with the rank of major in the Harvard University Unit, Base Hospital No. 5. He spent three and a half years in Europe, first as assistant chief and later as chief of the surgical service. Subsequently, he became senior consultant on general surgery for the European Theater of Operations, Office of the Chief Surgeon, Major General Paul Hawley. During this time, he was advanced to the rank of colonel and received the Legion of Merit.

Since his return, Dr. Zollinger has been chief consultant in general surgery for the Veterans' Administration professional service division under Major General Hawley, acting surgeon general.

Entering the Army in 1942 with the rank of captain, Dr. Morton later was advanced to major. He was with the radiological department of the 4th General Hospital, then chief of X-ray service for the 12th Station Hospital and the 42nd General Hospital.

Before entering the service, Dr. Zollinger was surgeon at the Peter Bent Brigham Hospital in Boston, and assistant professor at Harvard Medical School. He is a native of Millersport, Ohio.

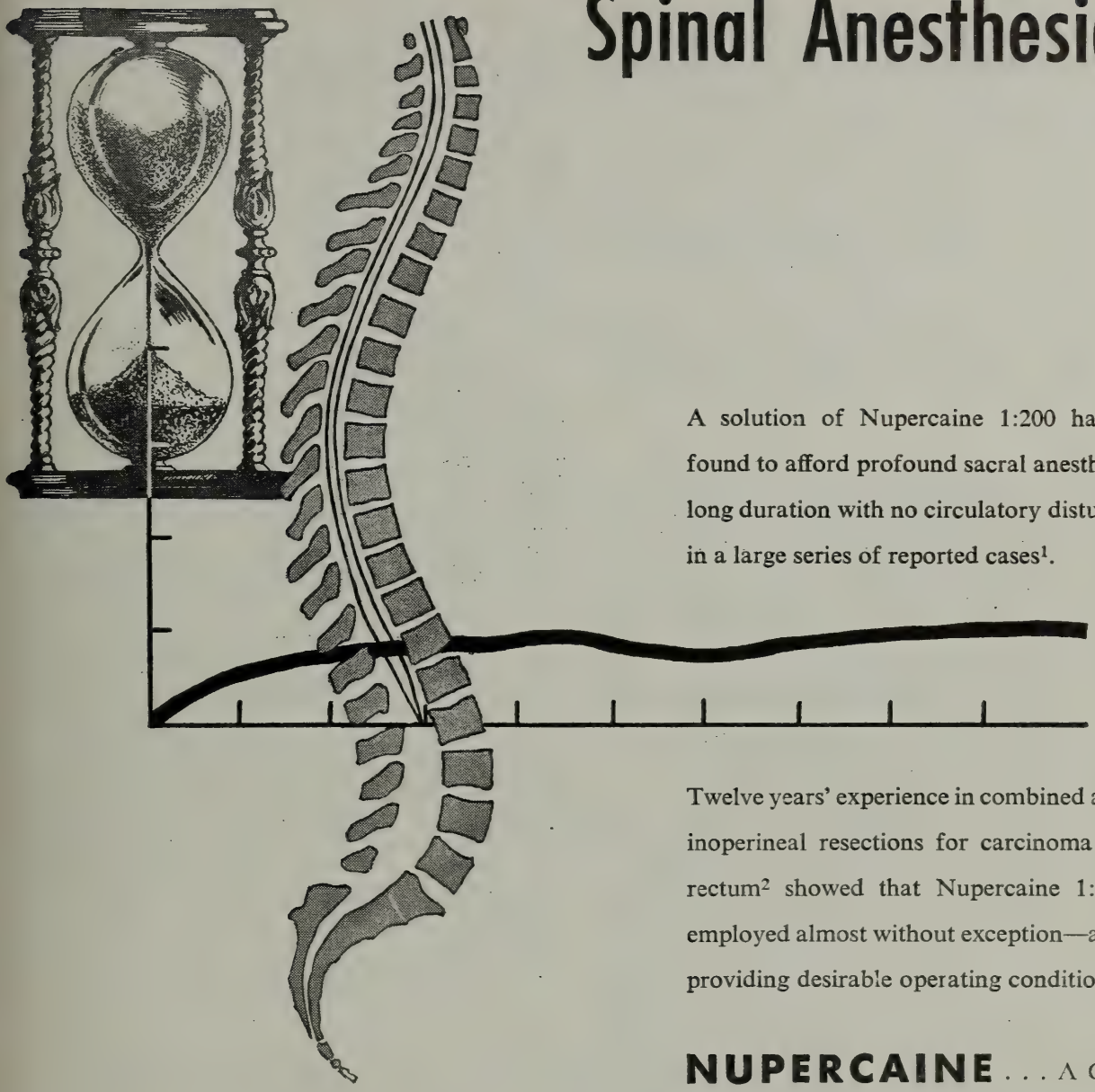
Dr. Morton, who was born in New Vienna, Ohio, was chief resident of diognostic and therapeutic radiology and radium therapy at Cleveland City Hospital and a member of the staff at Western Reserve University.

159th Meeting

The 159th semi-annual meeting of the Union District Medical Association and the Butler County Medical Society was held April 24 at the Hotel Manchester in Middletown. The program included an address, "Common Sense Pediatrics", by Dr. E. H. Baxter, Columbus; war pictures, "Medical officer with Patton's Army", Dr. Russell L. Malcolm, Richmond, Indiana; and an address on "Allergy", by Dr. John Mitchell, Columbus.

Columbus—Dr. Henry E. Wilson, Jr., has resigned from the staff of the Ohio State University College of Medicine to accept a new position at Northwestern University.

Prolonged Spinal Anesthesia



A solution of Nupercaine 1:200 has been found to afford profound sacral anesthesia of long duration with no circulatory disturbance in a large series of reported cases[1].

Twelve years' experience in combined abdominoperineal resections for carcinoma of the rectum[2] showed that Nupercaine 1:1500—employed almost without exception—aided in providing desirable operating conditions.

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1 Clement, F. W. & Elder, C. K.: Anesth. 4:516, 1943
2 Coller, F. A. & Ransom, H. K.: Surg. Gynec. & Obst., 78:304, 1944

NUPERCAINE—Trade Mark Reg. U.S. Pat. Off. identifies the product as alpha-butyloxy-cinchoninic acid—gamma-diethyl-ethylenediamide-hydrochloride.

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Names of 142 Additional Ohio Medical Officers Added to List of Those Separated from the Services

AS a result of information received by *The Journal* during the past four or five weeks, the names of 142 additional Ohio physicians have been added to the list of medical officers discharged from the services.

The following tabulation lists the names of those recently released or who started terminal leave. The city in which the physician practiced or resided prior to entering the service is shown in most instances. However, if he has changed locations and that fact is known, the place of relocation is indicated. The rank shown is based on the latest information on file with the State Association and may not be up to date in some cases.

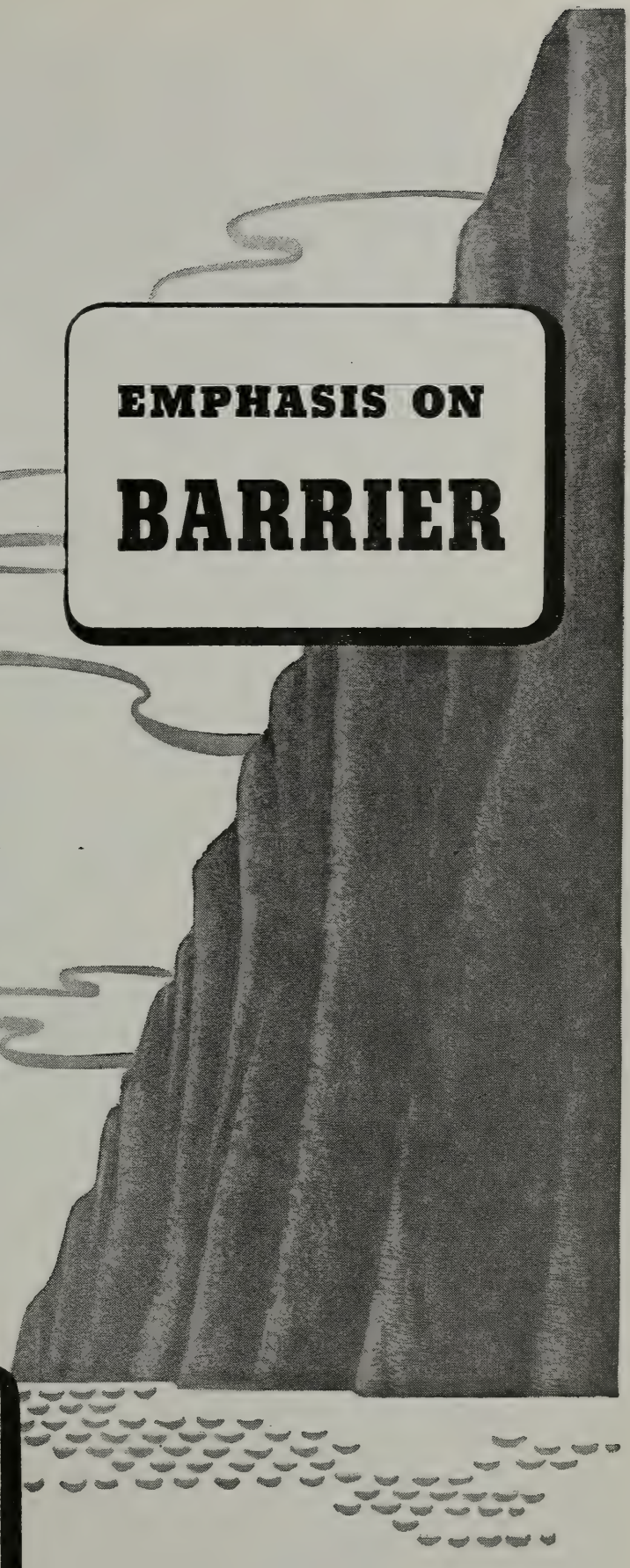
Name	City	Rank
Allison, H. W.	Akron	1st Lt., A.U.S.
Anzinger, Robert J.	Cincinnati	Major, A.U.S.
Bahrenburg, James H.	Canton	Lt. Col., A.U.S
Barr, Frederick G.	Dayton	1st Lt., A.U.S.
Beck, Harry W.	Canton	Major, A.U.S
Berns, Charles	Cleveland	Col., A.U.S.
Bowman, Harold J.	Canton	Lt. Col., A.U.S.
Boyle, Peter L.	Youngstown	Capt., A.U.S.
Brown, L. Emmitt, Jr.	Akron	Lt. Col., A.U.S.
Brown, Walter J.	Conneaut	Major, A.U.S.
Brumley, D. R.	Findlay	Lt. Col., A.U.S.
	(formerly of Tiffin)	
Buchanan, John R.	Youngstown	Capt., A.U.S.
Castle, Edward B.	Cleveland	Major, A.U.S.
Cava, J. F. Mingo	Junction	Major, A.U.S.
Chamberlain, Webb P., Jr.	Cleveland	Major, A.U.S.
Chambers, William R.	Hartford, Conn.	Capt., A.U.S.
	(formerly of Cincinnati)	
Chudde, Sam S.	Dayton	Capt., A.U.S.
Clark, Clyde E.	Dayton	Capt., A.U.S.
Cooper, Maurice P.	Miami, Florida	Lt. Col., A.U.S.
	(formerly of Toledo)	
Crone, John T., Jr.	Cincinnati	Major, A.U.S.
Davis, Adrian E.	Akron	Lt. Comdr., U.S.N.R.
Davis, Alexander N.	Dayton	Capt., A.U.S.
Dennis, Gerald H.	Dayton	Major, A.U.S
Dickie, John D.	Toledo	Capt., A.U.S.
Diggs, Arthur O.	Columbus	Lt. Col., A.U.S
	(formerly of Mansfield)	
Diller, Weldon E.	Rawson	Major, A.U.S.
Dougherty, John E.	Canton	Capt., A.U.S.
Drown, Willard G.	Warren	Lt. Col., A.U.S.
Dummer, Clyde M.	Dayton	Lt. Col., A.U.S.
Duncan, Charles H.	Columbus	Lt. Comdr., U.S.N.R.
Duncan, Wallace S.	Cleveland	Lt. Col., A.U.S.
Elkins, Charles W.	Cleveland	Major, A.U.S.
Englander, Howard H.	Cleveland	Capt., A.U.S.
Ferguson, Robert J.	Ashland	Major, A.U.S.
Fischbach, William M.	Cincinnati	Lt., U.S.N.R.
Forward, Donald D.	Ashtabula	Lt. Col., A.U.S.
Fowler, Evan C.	Sebring	Major, A.U.S.
Gallagher, John E.	Rossford	Capt., A.U.S.
Gault, Ross M.	Portsmouth	Capt., A.U.S.
Geer, J. G. Paul	Metamora	Lt. Comdr., U.S.N.R
	(formerly of Wauseon)	
Glorioso, John A.	Lima	Capt., A.U.S.
Glover, Donald M.	Cleveland	Col., A.U.S.
Grandin, W. R.	Dayton	Capt., A.U.S.
Gross, Joseph	Cleveland	Capt., A.U.S.
Gusman, Harry A.	Cleveland	Comdr., U.S.N.R.
Haire, W. T.	Cleveland	Capt., A.U.S.
Hamilton, Ian B.	Canton	Lt. Col., A.U.S
Harner, Ronald M.	Canton	Capt., A.U.S.
Hart, A. J.	Cleveland	Lt., U.S.N.R.
Hauser, Willard E.	Cleveland	Capt., A.U.S.
Henderson, William S.	Akron	Comdr., U.S.N.R
Herbst, Mark G.	Canton	Capt., A.U.S.
Herman, William W.	Cleveland	Major, A.U.S
Higley, Charles S.	Cleveland	Lt. Col., A.U.S.
Hill, Myron G.	Cleveland	Capt., A.U.S
Hirsh, Leon S.	Cincinnati	Lt. Comdr., U.S.N.R.
Howell, Homer P.	Oakland, Calif.	Capt., A.U.S.
	(formerly of Dayton)	
Inskeep, Lewis C.	Urbana	Major, A.U.S.
Kaufman, Karl F.	Cleveland	Capt., A.U.S.
Keiser, Harold L.	Fremont	Major, A.U.S.
Kelly, Donald A.	Cleveland	Lt. Col., A.U.S.
Kerschgens, Lambert J.	Steubenville	Lt.Comdr., U.S.N.R.
Kessler, Saul W.	Cleveland	Capt, A.U.S.
Kimmel, Alexander H.	Norwalk	Lt. Col., A.U.S.
King, Clair B.	Canton	Lt. Comdr., U.S.N.R
Kish, Louis S.	Cleveland	Major, A.U.S.
Klein, Julius B.	Cleveland	1st Lt., A.U.S.
Klinge, John E.	Massillon	Major, A.U.S.
Kobacker, J. Lester	Toledo	Comdr., U.S.N.R.
Koch, Carl A.	Cincinnati	Major, A.U.S.
Koenigshoff, John A.	Cleveland	1st Lt., A.U.S.
Koons, Ervin	Fremont	1st Lt., A.U.S.
Kovach, John S.	Cleveland	Lt. Comdr., U.S.P.H.S.
Kugler, Frank E., Jr.	Cincinnati	Major, A.U.S.
Lancione, Peter	Bellaire	Major, A.U.S.
Larrick, Lloyd E.	Norwood	Major, A.U.S.
Lauer, Howard	Dayton	Capt., A.U.S.
Lecklitner, Myron D.	Wilmot	Capt., A.U.S.
Leonard, Donald E.	Akron	Capt., A.U.S.
Leuchtag, Harry H.	Akron	Capt., A.U.S.
Macey, William N.	Cleveland	Lt. Comdr., U.S.N.R.
Maggiore, Jerome J.	Canton	Capt., A.U.S.
Marcus, L. J.	Cleveland	Major, A.U.S.
Martin, James F.	Cincinnati	Capt., A.U.S
Maxwell, Joseph A.	Montpelier	Lt., U.S.N.R.
McMath, Joseph S.	Cincinnati	Comdr, U.S.N R.
Meltzer, S. L.	Portsmouth	Major, A.U.S.
Meyers, George A.	Cincinnati	Capt., A.U.S.
Michaels, Samuel J.	Columbus	Major, A.U.S.
	(formerly of Akron)	
Miller, Alexander	Cleveland	Col., A.U.S.
Miller, Michael M.	Detroit, Mich.	Major, A.U.S.
	(formerly of Steubenville)	
Mohr, Truman J.	Lockland	Major, A.U.S.
Mollin, Lloyd P.	Cleveland	Capt., A.U.S.
	(formerly of Cincinnati)	
Moore, Frank R.	Athens	Lt., U.S.N.R.
	(formerly of Cincinnati)	
Morris, Harry D.	Cleveland	Lt. Comdr., U.S.N.R.
Murbach, Clarence F.	Archbold	Col., A.U.S.
Nulsen, Ray O.	Cincinnati	Major, A.U.S.
Nusbaum, F. W.	Chillicothe	Lt., U.S.N R.
Obert, Charles	Cleveland	Capt., A.U.S.
Orr, Paul F.	Perrysburg	Surg., U.S.P.H.S.
Osler, George E.	Newport, Ky.	Capt., A.U.S.
	(formerly of Cincinnati)	
Pastor, Julius W.	Cleveland	Capt., A.U.S.
Petznick, George W.	Cleveland	Major, A.U.S.
Pevaroff, H. H.	Cleveland	Capt., A.U.S.
Phillips, A. K.	Youngstown	Capt., A.U.S.
Pospisil, Rudolph J.	Springfield	Capt., A.U.S.
Possner, Howard E.	Wakefield, R. I.	Capt., A.U.S.
	(formerly of Youngstown)	
Prugh, Reed C.	Dayton	Capt., A.U.S.
Pumphrey, Robert E.	Dayton	Lt. Comdr., U.S.N.R.
Ralston, Louis G.	Niles	Capt., A.U.S.
Ramsayer, Herbert P.	Alliance	Capt., A.U.S.
Reed, Lewis K.	Youngstown	Major, A.U.S.
Renner, William J.	Cleveland	Lt. (j.g.), U.S.N.R.
Rheingold, Jack J.	Cincinnati	Major, A.U.S.
Riemer, Harry J.	Cleveland	Major, A.U.S.
Ritter, Karl F.	Lima	Major, A.U.S.
Roback, Harry N.	Cuyahoga Falls	Major, A.U.S.
Sackett, George L.	Cleveland	Col., A.U.S.
Schafer, Walter L.	Fremont	Comdr., U.S.N.R.
Schwartz, Abe L.	Cincinnati	Capt., A.U.S.
Scroggin, Frederick R.	Dry Ridge, Ky.	Capt., A.U.S.
	(formerly of Cincinnati)	
Sharp, Jack M.	Santa Cruz, California	Lt. Comdr., U.S.N.R.
	(formerly of Cincinnati)	
Sheinin, Louis	Akron	Capt., A.U.S.
Silver, Nathan	Cincinnati	Capt., A.U.S.
Solier, Richard W.	Bryan	Lt. Comdr., U.S.N.R.
Spreen, Arthur H.	Cincinnati	Lt., U.S.N.R.
Stark, J. J.	Belpre	Capt., A.U.S.
Stewart, Wilbur F.	Fostoria	Capt., A.U.S.
Tagett, H. O.	Geneva	Capt., A.U.S.
	(formerly of Rock Creek)	
Taggart, W. B.	Dayton	Lt. Comdr., U.S.N.R.
Treece, Harold K.	Arlington	Major, A.U.S.
Vecchio, Frank	Cleveland	Major, A.U.S.
Vinocur, J. L.	Cleveland	Major, A.U.S.
Voorhis, Charles C.	Kent	Lt. Col., A.U.S.
	(formerly of Cleveland)	
Warburton, R. T.	N. Canton	Lt., U.S.N.R.

AUTHORITATIVE clinical investigators place strong emphasis on the importance of the barrier in conception control.

In a recent comprehensive report,[1] physicians indicated an overwhelming preference for the diaphragm and jelly method (93% of 36,955 new cases).

In keeping with these expressed opinions we continue to suggest that for the optimum in protection the physician prescribe the combined use of occlusive diaphragm and spermatocidal jelly.

You assure your patient a product of highest quality when you specify Ramses REG. U.S. PAT. OFF.



Competent observers report:

"Jellies and creams used without mechanical devices yield relatively high protection, but studies have not proven them fully dependable to block the external os, or to invalidate all sperm."[2]

"When no type of occlusive pessary can be fitted, or when the woman refuses to use one, the only other reliable method is the use of the condom. With proper technic and instruction this method is highly reliable but has many disadvantages which the diaphragm method overcomes."[3]

1. Clinic Reports: Planned Parenthood Services in the United States. Human Fertility 10: 25 (Mar.) 1945.
2. Dickinson, R.L.: Techniques of Conception Control. Baltimore, Williams and Wilkins Co., 1942.
3. Warner, M.P.: J.A.M.A. 115: 279 (July 27) 1940.

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Name	City	Rank
Ward, David P.	Pemberville	Major, A.U.S.
Weintraub, Jos. D.	Cincinnati	Lt. Comdr., U.S.N.R.
Weir, David R.	Cleveland	Capt., A.U.S.
Weiss, L. L.	New York, N.Y (formerly of Canton)	Capt., A.U.S.
Wells, William D.	Louisville, Ky. (formerly of Milford)	Capt., A.U.S.
Welter, John A.	Youngstown	Capt., A.U.S.
Wilson, O. G.	Canton	Major, A.U.S.
Zlotnick, Sam	Youngstown	1st Lt., A.U.S.

Military News Notes

Changes in station: Capt. Charles W. McGavran, Columbus, Squadron E, 42nd AAFBU, AAF Reg. Hosp., Maxwell Field, Montgomery, Ala.; Maj. K. A. Owen, Akron, Enid AAF, Enid, Okla.; Maj. Wm. J. Slasor, Toledo, X-ray Dept., Wakeman Gen. Hosp., Camp Atterbury, Indiana; Capt. I. L. Levin, Lorain, Ward 23, Army and Navy Gen. Hosp., Hot Springs, Ark.; Capt. H. N. Miller, Cleveland, 1060 AAFBU, Greensboro, N. C.; Capt. John S. Kiess, Bucyrus, Section B-123 AAFBU, Seymour Johnson Field, Goldsboro, N. C.; Comdr. W. F. Lyons, Coshocton, Bldg. 1208, Great Lakes, Ill.; Capt. Omer Jasper, Cincinnati, Reg. Sta. Hosp., Keesler Field, Biloxi, Miss.; Capt. Edwin C. Faessler, Cincinnati, 1326 SCU, Reg. Hosp., Camp Lee, Va.; Capt. Samuel Beckerman, Cleveland, Med. Det., 543 EB and SR, APO 503 San Francisco; 1st. Lt. Lloyd J. Barson, Van Wert, CAS, Camp Stoneman, Calif.; 1st. Lt. James M. Anderson, Hamilton, 130 Sta. Hosp., APO 209, New York; 1st. Lt. Lawrence J. Schneider, Cincinnati, Pers. Cen., Med. Sec., Fort McPherson, Ga.; Lt. William G. Leary, Cincinnati, 108 Harrisburg Ave., Williamsburg, Va.; Lt. R. S. Koehler, Findlay, U. S. Naval Hosp., Jacksonville, Fla.; Lt. Raymond L. Hilsinger, Cincinnati, U. S. Naval Hosp., Shoemaker, Calif.; Lt. Charles Fralick, Columbus, Naval Air Facility, Columbus; Lt. (j.g.) Sanford R. Courter, Cincinnati, 2nd Bn., Med. Co., 1st Special Marine Brigade, Camp Lejeune, N. C.; 1st. Lt. Chas. V. Lee, Hamilton, 130th Sta. Hosp., APO 209, New York; Capt. Clyde G. Chamberlin, Hamilton, Percy Jones Gen. Hosp., Battle Creek, Mich.

* * *

Maj. E. S. Hill, Canton, has been in Korea since Sept. 8, 1945, having gone there with the advance echelon of troops from Okinawa. He was assigned to the 29th General Hospital at Seoul as chief of surgery when it first opened on Dec. 8. This is the only general hospital in Korea, and Maj. Hill finds the work "fairly interesting". He comments: "Our beds are full and one of our main problems each day is what we are going to do with the patients who may come in during the night. We see pretty much the usual patients of general surgery, plus some very bad burns and more than our share of bad accidents."

"Shipped from hosital to hospital" since being wounded in Mindanao, May 1, 1945, Lt. Col. R. R. Pliskin, Akron, was discharged recently from Valley Forge General Hospital, and is now taking a graduate course in general surgery at the University of Pennsylvania, Philadelphia.

* * *

Col. Joseph M. Hayman, Jr., Cleveland, has been awarded the Legion of Merit for his outstanding work as chief of medical service at the Army's Tropical Disease Center, Moore General Hospital, Swannanoa, N. C. Dr. Hayman returned to his position of professor of clinical medicine and therapeutics at Western Reserve University School of Medicine in January. Entering military service in January, 1942, he was in the southwest Pacific 30 months with the Lakeside Hospital Unit before going to Swannanoa in August, 1944.

* * *

Maj. Gen. Paul R. Hawley has retired from the Army, closing a career of 29 years in the Army Medical Corps, to accept an appointment as chief medical director of the Department of Medicine and Surgery in the Veterans Administration.

* * *

Lt. Col. James M. Harsha, Washington C. H., commanding officer of the 385th Med. Gen'l. Disp. for GHQAFPAC, moved his unit from Manila, P. I., Feb. 1, to Tokyo. His headquarters are in the famous Daielchi Bldg., which houses all GHQ and General MacArthur's offices, facing the Imperial Palace Grounds.

* * *

Capt. Franklin C. Schlueter, Cincinnati, is stationed on the island of Guam, with the 501st Bomb. Group.

* * *

Now consultant in physical therapy in the Office of the Surgeon General, Maj. Donald L. Rose, Dayton, was stationed at Walter Reed Hospital for more than four and one-half years, being chief of the physical therapy and fever therapy sections during most of that period. Before returning to civilian practice he intends to do some postgraduate work through a fellowship under the Baruch Committee on Physical Medicine.

* * *

The Legion of Merit has been awarded to Col. Franklyn A. Rice, Cleveland, for "his superior performance of duty as chief of the surgical service, Billings General Hospital, from March 25, 1943 to Dec 3, 1945". The citation reads: "His outstanding ability as supervisor of the surgical service and as an operating surgeon have been a tremendous contribution to the success of Billings General Hospital. His surgical judgment and his capacity for achievement have been an inspiration to all associated with him". Col. Rice is now chief of surgical service at the

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'DELVINAL'
Sodium
Vinbarbital

WHEN YOU MUST PRESCRIBE A SEDATIVE



SHARP & DOHME

Regional Hospital, Fort Knox, Ky. He was promoted to his present rank on March 27.

* * *

Lt. Col. Jerry O. Crist, now at Wakeman General Hospital, Camp Atterbury, Indiana, has been authorized to wear the Army Commendation Ribbon by direction of the Secretary of War. The citation reads: "Accomplished with notable distinction his assignments as Commanding Officer of Post Hospital, Camp Breckinridge, Kentucky, from Oct. 6, 1942 to June 18, 1944. Exhibiting outstanding initiative, judgment, and attention to duty and professional skill, Lt. Col. Crist has brought commendation to his profession and this command".

* * *

In the April issue of *The Journal*, page 428, the name of Dr. Samuel C. Lind, Cleveland, was included in the list of physicians separated from the service. He was designated: "Capt. A.U.S." Actually, Dr. Lind was a four-striper in the Navy! His rank should have read: "Capt., U.S.N.R."

* * *

Lt. Col. Burton E. L. Hyde, Troy, is surgical consultant for the Eighth Army, which includes all the hospitals in Japan. He reports that the hospitals over there are now fast becoming stateside in atmosphere, some so much so, that the only reminders of being in Japan are the kimonoed girls who wait table in the messes.

WIN PROMOTIONS

Name	City	Rank
Harsha, James M.	Washington C.H.	Lt. Col., A.U.S.
Lyons, W. F.	Coshocton	Comdr., U.S.N.R.
Placak, Joseph C., Jr.	Cleveland	Comdr., U.S.N.R.
Pliskin, Reuben R.	Akron	Lt. Col., A.U.S.
Rice, F. A.	Cleveland	Col., A.U.S.
Roach, William L.	Cincinnati	Lt. Col., A.U.S.
Slasor, William J.	Toledo	Major, A.U.S.
Stilwill, Maurice E.	Massillon	Capt., A.U.S.
Tetalman, Sam	Cleveland	Capt., A.U.S.

Otolaryngology Refresher At Illinois

A one-week didactic and clinical refresher course in otolaryngology will be presented for specialists in this field from May 13 to 18 by the University of Illinois College of Medicine, Chicago. A special course in broncho-esophagology will be given from June 3 to 15. It will include lectures, animal and cadaver demonstrations, diagnostic and surgical clinics.

A recent poll of the members of the Wayne County (Detroit) Medical Society regarding their attitude on the Wagner-Murray-Dingell bill shows an overwhelming vote in opposition to it. Out of a resident active membership of 1,665 at the time of polling, there were 902 replies, with 876 opposed to the bill, 23 in favor, and three undecided.

Uniform Fees Will Be Paid to Physicians Attending E. M. I. C. Cases Effective May 1

Authorizations for obstetrical and pediatric care under the Emergency Maternity and Infant Care Program made on or after May 1, 1946, will provide for uniform fees for all physicians attending such cases, it has been announced by State Director of Health Roger E. Heering.

This action was taken by Dr. Heering on recommendation of the Advisory Committee to the Division of Maternal and Child Hygiene of the Ohio Department of Health after consideration of protests received from The Council of the Ohio State Medical Association, the Dayton Obstetrical Society, and a number of county medical societies with respect to the policy which has been in effect, authorizing higher fees in E.M.I.C. cases to physicians who are diplomates of American specialty boards.

On and after May 1, all physicians handling obstetrical cases will be paid a maximum fee of $50.00 and all physicians handling pediatric cases will be paid a maximum fee of $24.00 for the first three weeks of care.

At the same time, the Advisory Committee adopted a resolution requesting Dr. Heering to inform the U. S. Children's Bureau that the Ohio Advisory Committee advocates amendments to the Bureau's regulations so as to permit an E.M.I.C. claimant to use her own funds to supplement the maximum allowances under the E.M.I.C. program in the payment of medical expenses.

The committee pointed out that such a change would enable a claimant to utilize the services of any physician with whom mutually agreeable arrangements could be made with respect to the medical fee.

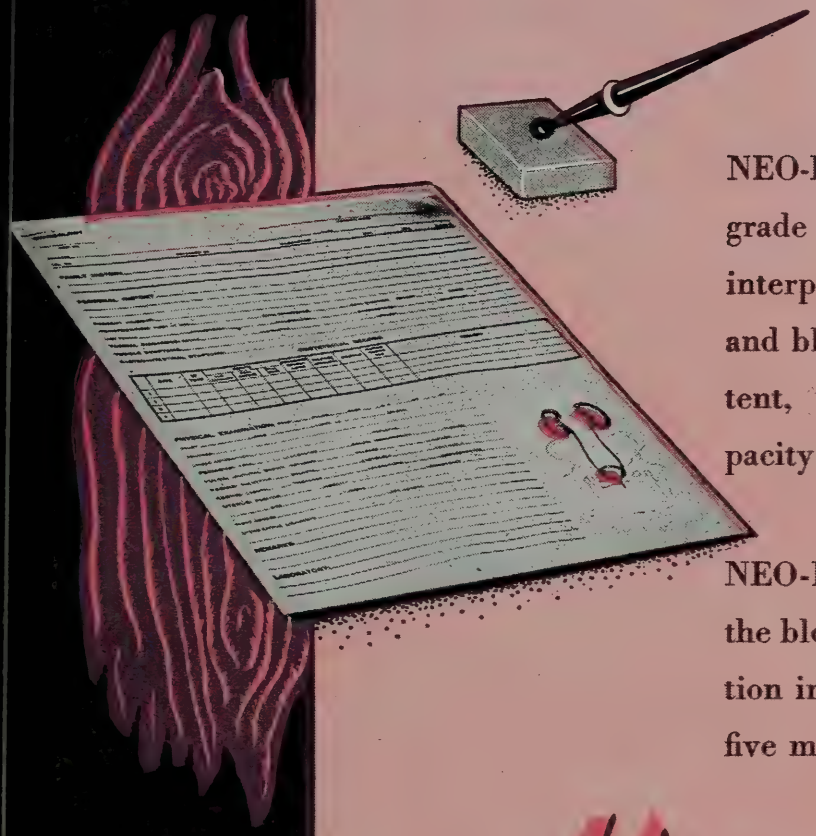
Under the present regulations, an E.M.I.C. claimant can not receive the Federal benefits if she uses personal funds as a supplement payment to the attending physician. This deprives some claimants of the opportunity to select their own physicians when such physicians have refused to participate in the Federal plan.

Postgraduate Course at Toledo

The 18th annual postgraduate course sponsored by the Academy of Medicine of Toledo and Lucas County was held April 17, 18, and 19, in the Academy Auditorium, Toledo, Dr. Sidney A. Portis, associate professor of medicine, University of Illinois, addressed the group on "Psychosomatic Medicine".

Lorain—Dr. Michael Kolczun, Lorain, recently talked on bone surgery to the pupils at Longfellow Junior High School of that city.

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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

OUR SUGGESTION FOR A FIVE-YEAR HEALTH PROGRAM

Senator Murray, of the Wagner, Murray, Dingell trio, has suggested a five-year program "to make Americans healthier". He wants the A.M.A., the American Dental Association, and "some 180 other organized groups" to submit their opinions as to what should be the "specific health goals" for the next five years.

We haven't been asked but nevertheless we will put in our two-bits worth.

If Mr. Murray will just see to it that the Federal Government keeps its nose out of the business of the medical profession, voluntary health agencies, and official state and local health agencies, he won't have to worry about the next five years.

The medical profession, dental profession, and many other organizations in the health field were planning and doing things for the health of the people long before Mr. Murray was out of diapers—we are quite sure long before he wrapped himself in the toga which appears to weigh so heavily upon his shoulders.

Our suggestion is for a moratorium on political interference in the field of health not only for the next five years but indefinitely.

If Senator Murray would look at the record books he would find plans and activities galore under the sponsorship of voluntary organizations —enough to make hundreds of five-year health programs.

DEMOCRACY AS PRACTICED BY THE GENTLEMAN FROM MONTANA

We hate to give the Senator from Montana, Mr. Murray, any more publicity, but local pride forces us to give him just one more clip under the chin.

Probably you saw where he ordered Senator Taft, Ohio, to "shut up" or be thrown out of a committee hearing, when Mr. Taft denounced the W-M-D Bill as the most socialistic measure ever presented to the American Congress.

He can't do that to one of our Ohio boys, you say?

Well, he did.

Probably just a dress rehearsal of what may be expected if the W-M-D health dictatorship is established, as Mr. Murray hopes.

Go get him, Bob! You've tangled with experts.

The Cleveland Plain Dealer hit the nail on the head when it said editorially:

"Senator Taft deserves congratulations for challenging the dictatorial tactics with which Senator Murray of Montana rules the education and labor committee.

"In tilting with Murray, the Ohio senator was telling off the one man who is more responsible than any other for the failure of Congress to apply to organized labor any of the reasonable rules for the protection of the public which have long since been applied to business and industry.

"As Ralph Robey said in a recent issue of Newsweek, Senator Murray has become one of our major social problems. His point of view is that labor can do no wrong, and because of his iron rule over the labor committee he has been able either to keep any healthy labor legislation from reaching the Senate floor or to emasculate it so that it is ineffective once it goes there.

"It is time a bit of democracy was practiced by the Montana senator who throws the word around with such great zeal."

IT CAN CLICK IF ALL WILL HELP WITH THE JOB

Maj. Gen. Paul R. Hawley, medical director of the Veterans Administration, addressing the Medical Society of the County of New York, recently, issued the warning "if we doctors don't make this plan succeed, then before long we shall all be working for the government", in commenting on the V.A. program to use home-town private practitioners to provide medical care to eligible veterans.

As soon as the Central Office of the Veterans Administration at Washington approves the proposal submitted by the Ohio State Medical Association for such a program in Ohio, members of the Ohio State Medical Association will be asked to participate.

The success of the Ohio program will depend on the willingness of all members of the Association to take part in the plan.

Before he refuses to participate, a physician should ponder the words of General Hawley.

MAC GETS THE DOPE RIGHT FROM THE FEED BOX

The Hon. J. Harry McGregor, Republican Congressman from the Seventeenth Congressional District of Ohio (Delaware, Licking, Knox, Coshocton, Ashland, and Richland counties) likes to know what the folks back home have to say on the hot questions before Congress.

This being the case, Mac sends out a questionnaire to a cross-section of his constituency

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We cordially invite you to discuss your beauty potential with the Cosmetic Consultant who distributes our products in your community. Beauty, we feel, is an intimate subject—one that is best discussed in the privacy of your home.

Too often, we are inclined to take ourselves for granted. It somehow escapes us that our outward appearance reflects our personality, our individuality, our ideas; that it is wonderfully adaptable to change, to improvement. We have a tendency to regard our physical aspects for all the world as though they were the drapes in the living-room which we intend to change one of these days, when we get around to it, for something more up-to-date and colorful. We put it off and put it off—and why?

Seeing ourselves as others see us helps immeasurably to arrive at that all-important detached viewpoint without which the art of self-improvement is greatly hampered. And it is here that the Cosmetic Consultants who distribute our products can be of real service to you; for, in effect, you see yourself through their eyes, aided by our Selection Questionnaire which, as it is answered, unfolds a word picture of your type and condition of skin and of your coloring, viewed cosmetically.

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every once in a while. He just completed one of his sampling surveys.

If the tabulation proves anything, the folks in the 17th District haven't fallen for the Truman health proposal as 83 per cent of the replies expressed opposition to the Truman scheme.

Nevertheless, we don't believe Harry's folks are reactionaries. By that we mean, we don't believe they think improvements—many of them —can't, or shouldn't, be made in Ohio's organized health programs. And, we don't believe they would turn thumbs down on a good voluntary prepayment medical care plan such as, for example, the program offered by Ohio Medical Indemnity, Inc., sponsored by the physicians of Ohio.

Before long, we hope Ohio Medical Indemnity, Inc., can start activities over in the McGregor district. The folks over there deserve an opportunity to get in on something good like an Ohio Medical Indemnity contract.

THE RIGHT WAY, WRONG WAY, AND WAY THE ARMY DOES IT

After talking to some of the boys just back from service with the Army Medical Corps, we suspect there is something to the old saying: There is a right way, a wrong way, and the way the Army does it, or something like that.

Unfortunately the Army never became fluid enough to modify its table of organization within the Medical Corps. It never seemed to be able to work out a thoroughly satisfactory schedule of assignments whereby talent could be used in the right slot. It never overcame the red tape of by-gone days.

Naturally, this is all water over the dam. However, right now is the time to see that it doesn't happen again. One prime item on the docket of organized medicine should be to develop a plan which will eliminate waste of medical personnel in the armed forces and to insist that the War and Navy Departments adopt such a plan.

DEPENDS ON WHOSE CORNER YOU HAPPEN TO BE IN

We see by the papers that President Truman saw fit to spank one of the Admirals because he engaged in what the President termed "lobbying" against the administration's proposal for merger of the armed services into one defense agency.

Funny, isn't it how the shoe pinches when it's on the wrong foot?

We don't remember seeing or hearing anything about Mr. Truman criticizing Dr. Parran, Mr. Watson Miller, Mr. Falk, Ph. D., Mr. Altmeyer, and the rest of the boys and girls of the Federal Security Agency and Public Health Service for the lobbying they have been carrying on in favor of the Wagner-Murray-Dingell Bill.

Nor, to the best of our knowledge and belief, has Mr. Truman seen fit to slap Dr. Martha Eliot of the Children's Bureau on the wrist because she has been lobbying for the so-called Pepper maternal and child health bill.

Incidentally, Senator Pepper, we understand, would like to have so-called "lobbying" by "entrenched, special-interest groups" investigated by Congress.

We're for it providing they investigate the biggest lobby group first—namely the Federal office holders, especially those who want to see democratic processes kicked out the window.

PARTIAL REPORT FROM THE JURY

Recently, the proposal for national compulsory insurance was debated before the Cleveland Town Meeting. R. Clyde White, Ph. D., professor of public welfare, took the affirmative side; David M. Keating, M. D., chairman of the public policy committee of the Cleveland Academy of Medicine, the negative side.

Ballots carried in *The Cleveland News* with a report of the statements made by the debaters were marked by readers and sent to *The News*. Ninety-three per cent supported the views of Dr. Keating who opposed the question.

Of significant interest, however, were the comments of readers published in *The News*. They really reveal the views which many people have about the Truman plan, the Wagner-Murray-Dingell Bill, etc., and why they are objectionable to so many.

Here are excerpts from some of the letters received by *The News*. Read them carefully. They give you a hunch for fresh approach when discussing this question with your own patients:

"I have always been thankful that I had a doctor in whom we all had great confidence whom I could call to take care of my children . . . . Why should the government interfere with a system that has proved itself?"

"This health insurance bill would kill incentive in a young doctor."

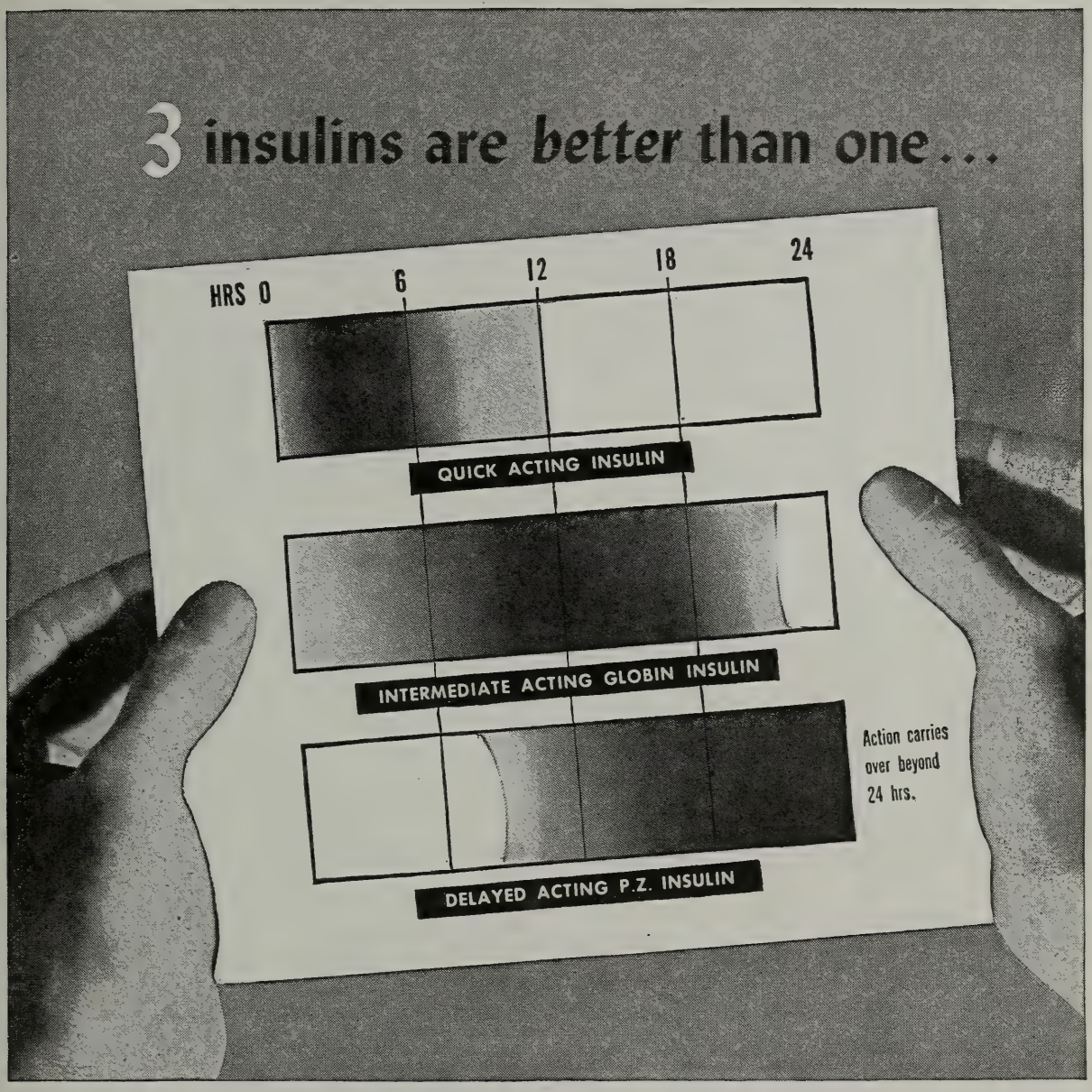
"We must not permit the health of a nation, our country, to be permanently impaired by the advice of some inexperienced or incompetent doctors who have small practices and powerful friends."

"We can be thankful that we still have the right to protect ourselves against such communistic legislation."

"It is a threat to free enterprise . . . . a way out for poorer doctors."

"I can honestly say that it is one of the biggest rackets for exploiting of the sick and the poor that was ever forced on the American public and the medical profession."

"I thought I was living in America, a free



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country, where we could make our own choice of what to do."

"We always paid our doctor bills. Why worry about it now? We want our taxes cut, not raised."

"Let us be Americans and have what our Constitiution was meant for, freedom to do our own thinking."

"For heaven's sake, give the American working man credit for knowing how to run his own affairs. Compulsion is hard to digest."

"Why substitute phony bills to socialize us?"

"And, I do not want any more deductions from my pay check by government edict."

"It will encourage shoddy practice and diagnosis."

"It is just another way for our politicians to hold a job at the public's expense."

"This is not a health bill but a plain unadulterated racket to put people on the payroll to vote for the party in power. . . . The only clear thing in the conglomeration of words and restrictions in the bill is that you pay three per cent."

"The professor states that a board of appeals will be set up. One can imagine trying to get an appeal to a board of bureaucrats at 3 o'clock in the morning in the case of a matter of life or death. Did Professor White ever try to get a quick decision from the WPB, the OPA, or any other bureau?"

Officials of Second District Meet in Dayton for Business Session

Officers, delegates, and alternate-delegates of the county medical societies comprising the Second Councilor District of the Ohio State Medical Association, held a dinner-meeting, Wednesday evening, April 17, at the Hotel Van Cleve, Dayton. There were 20 physicians present, including Dr. H. C. Messenger, Xenia, Councilor for the Second District, and one or more representatives of each of the following counties: Champaign, Clark, Drake, Greene, Miami, and Montgomery. There were no representatives from Shelby or Preble counties.

Following dinner, the meeting was called to order by the President, Dr. Roy S. Binkley, Dayton, and the minutes of past meetings were read and ordered approved. The acting treasurer, Dr. Wm. H. Hanning presented a report concerning the finances of the organization. This revealed that there was deposited in the Merchants Bank Savings account in Dayton the sum of $3232.30; and that the sum of $1212.90 remained in the Franklin Savings and Loan which is in the process of liquidation. A 5 per cent dividend will soon be paid on this amount which is expected to be the last to be received. With this dividend it is expected that the resources will be approximately $3456.00; and that approximately $1000.00 will be lost in the building and loan account.

A nominating committee composed of Drs. Hogue, Leyda, Gillette, and Gardner was appointed by the President.

Dr. Messenger discussed the need of increasing the Ohio State Medical Association dues from seven to fifteen dollars, in order to institute a better public relations program in the State. Dr. G. A. Woodhouse, delegate to the A.M.A., reported on national public relations programs which had been instituted by other state societies and the A.M.A.

A poll of the various counties in the District concerning the present annual dues revealed that from $8.00 to $30.00 was the present range of annual dues; and none of the representatives from these counties objected to the raise in State dues. It was moved by Dr. Hogue, seconded by Dr. Dooley, and passed unanimously that the Second Councilor District Medical Society is favorable to the proposed increase of State dues.

There was a general discussion of legislative activities, of State and National Organizational Medical Activities, which was of much general interest, and responses were obtained by all state delegates and also the A.M.A. delegate Dr. Woodhouse. It was moved by Dr. Gillette, seconded by Dr. Gardner, and passed, that the delegate to the A.M.A. be supported in his activities by the district organization.

The proposed schedule of the E.M.I.C. which would allow a larger fee for obstetrical deliveries by specialists over that allowed to general practitioners was discussed by Dr. Dooley. He stated that a Resolution against this differential fee schedule would be presented to the House of Delegates of the State Medical Association at the annual meeting. It was moved by Dr. Dooley, seconded by Dr. Gillette, and passed, that the Second Councilor District Medical Society is opposed to this differential fee schedule and that the proposed resolution against it should be supported by the delegates.

Dr. Hogue as chairman of the Nominating Committee, proposed a standing period of silence as tribute to Dr. H. H. Hanning, deceased, who had been treasurer of the Society since its inception.

The following slate of officers was presented by the committee and elected: President, Dr. J. E. Gillette of Darke County; Secretary, Dr. G. A. Woodhouse, Miami County; treasurer, Dr. Wm. H. Hanning of Montgomery County.

It was moved by Dr. Dooley, seconded by Dr. Baker, and passed that the treasurer be instructed to place the funds of the organization in an institution where the best interest return could be obtained with safety.—Geo. A. Woodhouse, M.D., Secretary.

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In Memoriam

Frank Clinton Anderson, M.D., Mt. Vernon; Ohio State University College of Medicine, 1911; aged 58; died Mar. 12; member of the Ohio State Medical Association and the American Medical Association. Dr. Anderson had been superintendent of the Ohio State Sanatorium, Mt. Vernon, for 22 years until he re-entered private practice in 1942. He was vice-president of the Knox County Medical Society, 1924-1925; legislative chairman in 1925, 1926, 1927, and 1931; delegate from 1930 through 1941; and secretary-treasurer, 1943-1944. He is survived by his widow, a son, a daughter, and his mother.

Oliver Parker Coe, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1901; aged 72; died April 6; member of the Ohio State Medical Association and Fellow of the American Medical Association. Dr. Coe was formerly Hamilton County Coroner; a member of the Masonic Lodge, and Sigma Chi and Nu Sigma Nu fraternities. He is survived by his widow, two brothers and two sisters.

Herman Goldsmith, M.D., Lancaster; University of Leipsic Medical Faculty, Saxony, 1911; aged 67; died Mar. 18; member of the Ohio State Medical Association and American Medical Association. Dr. Goldsmith came to this country from Germany in 1938; came to Ohio in 1939; was licensed to practice medicine in 1940, and was naturalized in 1944. Surviving are his wife, a son, and a daughter.

Aaron Jacoby, M.D., Steubenville; University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, 1919; aged 53; died Mar. 15; member of the Ohio State Medical Association and the American Medical Association. Dr. Jacoby had practiced medicine in Steubenville for the last 22 years; he was secretary of the Jefferson County Medical Society in 1926; president in 1927; delegate in 1931; and legislative committee chairman from 1933 through 1935. He was a member of the Masonic Lodge; Elks Lodge; and Temple Beth El. He is survived by his widow, a son, two sisters, and a brother.

Samuel Fosdick Jones, M. D., Pasadena, Calif.; Columbia University College of Physicians and Surgeons, 1902; aged 72; died Mar. 24; Fellow of the American Medical Association and American College of Surgeons, and Diplomate of the American Board of Surgery. Dr. Jones, a native of Cincinnati, had retired 10 years ago to live in Pasadena. He had practiced in Denver for 25 years, and served as a Major in the Army Medical Corps in World War I. He is survived by his widow, a brother, and two sisters.

Died While in Military Service

Herman Matthew Turk, M.D., Lima; Ohio State University College of Medicine, 1929; aged 43; member of the Ohio State Medical Association, the American Medical Association, and the American Psychiatric Association. A medical officer in the A.A.F., Maj. Turk was reported missing on an operational flight from Algiers to Florence, Italy, on Jan. 23, 1945, and was later listed as killed on that date. He had been in the service for about four years, and was formerly superintendent of the Lima State Hospital. Maj. Turk set up an examining board for cadets at Kelly Field, Tex., and later spent two years teaching neuropsychiatry at the School of Aviation Medicine at Randolph Field. He also served on the faculty of Our Lady of the Lake College at San Antonio. In May, 1944,, Maj. Turk was assigned to the 12th A.A.F. in Italy as flight surgeon and later became chief psychiatrist. At the time of his death, he was doing psychiatric research in pilot failures. Surviving are his widow, two sons, and his parents.

Ivan J. Baumgartner, M.D., Cleveland; Western Reserve University School of Medicine, 1944; aged 27; died Mar. 23. Dr. Baumgartner had been in the Army Medical Corps for more than a year and was stationed at Warner Robins Field, Georgia. Surviving are his widow, a daughter, his parents, and a sister.

Newton Wilson Kaiser, M.D., Toledo; University of Western Ontario Medical School, 1916; aged 58; died Mar. 24; member of the Ohio State Medical Association and the American Medical Association. Dr. Kaiser was assistant superintendent and clinical director of the Toledo State Hospital. He had been on the staff since 1924, had engaged in research and in the malaria treatment of syphilis and, according to reports, was the first in Ohio to introduce insulin therapy in the treatment of certain mental disorders. He was in charge of the mental hygiene clinic of the Toledo District Nurses' Association, and member of the staffs of Toledo, Mercy, Robinwood, St. Vincent's, and Flower hospitals. He is survived by his widow, a son, a daughter, a sister and two brothers.

Clyde Wallace Kirkland, M.D.; Bellaire; Ohio State University College of Medicine, 1911; aged



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65; died Mar. 25; member of the Ohio State Medical Association and Fellow of the American Medical Association. Active in the work of the state organization, Dr. Kirkland was Seventh District Councilor of the Ohio State Medical Association from 1934 through 1940. He practiced medicine in Bellaire from 1916 until his retirement a few years ago. He was a delegate of the Belmont County Medical Society in 1922, 1927, 1933, and 1934, and secretary-treasurer from 1924 until the time of his death. He was president of the Ohio Public Health Association, 1923-1924; a charter member and past president of the local Kiwanis Club; and a member of the Masonic Lodge and the Presbyterian Church. He is survived by his widow, a son, and a brother. Another son was killed while serving in the Army Air Corps in the Pacific area.

Joseph D. Marshall, M. D., Hamilton; Pulte Medical College, Cincinnati, 1891; aged 78; died Mar. 12. Dr. Marshall had practiced for more than 50 years. He is survived by his widow, one son, a daughter, his mother, and two sisters.

Albert Harold Mayer, M.D., Alliance; Ohio State University College of Medicine, 1912; aged 56; died April 2. Dr. Mayer had practiced medicine in Alliance for 31 years, coming to that city from Meadville, Pennsylvania. He was prominent in Alliance golf and bowling circles and was a member of the Knights of Columbus and the Catholic Church. He is survived by his widow, two sons, two daughters, and a brother.

John Daniel Miller, M.D., New York City; Hahnemann Medical College and Hospital of Philadelphia, 1903; aged 68; died April 6. Dr. Miller was a native of Dayton, and practiced medicine there until 1910. He served as a major in the Army Medical Corps in World War I, and later served as shipboard physician for various maritime companies. He is survived by two sisters and two brothers.

John Chadwick Oliver, M.D., Cincinnati; Miami Medical College, Cincinnati, 1885; aged 84; died Mar. 14; member of the Ohio State Medical Association; Fellow of the American Medical Association; Fellow of the American College of Surgeons; member of the Southern Surgical Association, and Professor Emeritus in Surgery at the University of Cincinnati College of Medicine. Dr. Oliver was the last surviving member of the original staff of Christ Hospital, which was organized in 1889 by Dr. Cornelius G. Comegys. He continued to serve as consultant on surgery at that hospital after his retirement, thus rounding out 60 years of service in the medical profession. He was a demonstrator and professor of anatomy at the old Miami Medical College, and later as its dean, worked with several other medical men to unite that school with the Medical College of Ohio to form what is now the University of Cincinnati College of Medicine. He became dean of that institution upon the death of Dr. C. R. Holmes, with whom he had co-operated in the establishment of the college and of General Hospital in Cincinnati. He served as a medical officer in World War I. Dr. Oliver was the grandson of Dr. David Oliver, who practiced in Cincinnati in the early 19th century. The medical family is continued today by two sons: Dr. Wade Wright Oliver, professor of bacteriology, Long Island Medical College, Brooklyn, and Lt. Cmdr. Symmes F. Oliver, Medical Corps, U.S.N., now on duty at the U.S. Marine Hospital, Galveston. A daughter also survives.

James Richard Reeves, M.D., Columbus; Indiana University School of Medicine, 1933; aged 42; died April 11; member of the Ohio State Medical Association and the American Medical Association. Dr. Reeves was assistant professor of medical research at the Ohio State University. He entered the medical corps of the U.S. Army in 1940 and was discharged with the rank of major not long before his death. He received injuries while on duty at Saipan during the war in the Pacific. He had established quarters for private practice in Columbus a short time after leaving the armed services. He is survived by his wife, his parents, a sister, and a brother.

Raymond Howard Schroeder, M.D., Dayton; Ohio State University College of Medicine, 1938; aged 33; died Mar. 30; member of the Ohio State Medical Association and the American Medical Association. Dr. Schroeder had practiced in Quincy, Ohio, until he entered the Army Air Corps in 1942. He served as flight surgeon with the 16th Fighter Squadron and received the Air Medal for his work in China, where he was stationed for 26 months. He was discharged from the services about a month ago. Surviving are his widow, a daughter, and his parents.

Alfred Theodore Shohl, M.D., Mirror Lake, N.H.; Harvard Medical School, 1914; aged 57; died Mar. 25; member of American Pediatric Society and American Society for Clinical Investigation. A native of Cincinnati, Dr. Shohl was on the staff at Johns Hopkins, Yale, and Western Reserve University before becoming affiliated with Harvard Medical School 14 years ago. Surviving are his widow, one son, two daughters, and one brother.

Bennetta D. Titlow, M. D., Springfield; Women's Medical College of Pennslyvania, Philadelphia, 1891; aged 78; died Mar. 7; member of the Ohio State Medical Association and the American Medical Association. Dr. Titlow had practiced in Springfield from 1892 until her re-

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tirement seven years ago. She served in the Army Medical Corps in France in World War I, and was a member of the Altrusa Club. A brother survives.

Frank Edgar Weeks, M.D., Kipton; Western Reserve University School of Medicine, 1883; aged 89; died Feb. 27. Dr. Weeks had practiced at Kipton, Vermilion, and Clarksfield, and was also an author, newspaper publisher, and surveyor. Surviving are his widow, two sons, and a daughter.

Compulsory Sickness Insurance Plan Rejected by N.Y. Study Group; Alternative Proposals Submitted

The New York Commission on Medical Care has submitted its report to the N.Y. Legislature. The Commission is made up of nineteen members. This report consists of a majority report signed by nine members. In the majority report it was recommended that consideration be given to the following: 1. Extension of public health and welfare services; 2. State aid for hospital construction; 3. Development and extension of diagnostic aid facilities; 4. State support for specific medical research projects.

In the majority report it is stated that certain principles have become apparent. These are: 1. Adequate medical care should be made more readily available to all residents of the State; 2. Persons to be benefited should pay a material part of the cost; 3. There should be freedom of choice of doctor by patient and of patient by doctor; 4. There should be as little government interference in the practice of medicine as is consistent with proper standards of medical service; 5. Good voluntary medical and hospital insurance plans should be encouraged.

This majority report also stated that a comprehensive plan for medical care, including hospitalization, physician's care at home, in the office, and in the hospital, nursing care, diagnostic services, and limited dental care, would probably cost at least $400,000,000 a year, which would mean a cost of at least $30 per capita. Members signing the majority report are of the opinion that this sum represents too great an expenditure to be imposed on the people of the State either directly or indirectly through governmental authority until there has been more experience in the field of medical and hospital insurance.

There were four minority reports. Minority report No. 1 called for a program of medical, dental, hospital and nursing care for children under eight, estimated cost being $77,000,000. This report also recommends a hospital licensure law, and provision of hospital care for tuberculosis and mental diseases at public expense rather than under the means test now being applied in the State institutions. It also recommends that provision be made for patients chronically addicted to drugs or alcohol.

Minority report No. 2 advocated a compulsory comprehensive sickness insurance plan. Minority report No. 3 agreed with the majority report to a great extent with the exception that it puts the cost at $500,000,000 and approximate cost per capita of $35. Minority report No. 4 stated that its chief disagreement with the report of the majority of the Commission is that the statement does not reaffirm a belief that social insurance represents the most practical means in sight for financing medical and hospital care for large numbers in the low income groups.

Governor Dewey's message on health was delivered to the Legislature after the Commission had reported. In that message he called attention to the five separate reports of the members of the Commission which reflected the sharp disagreement amongst all people as to the means by which a broad program for medical care can be provided. He said in this message, "Obviously, this problem must await further study and disposition by the Congress of bills on this subject pending before it". With these short statements he disposed of the matter of compulsory health insurance.

In his message he went on to outline an extension of the Health Department, particularly in the field of tuberculosis, and the strengthening of state aid to local health departments. He also called attention to the need of professional recruitment and training program and the recommendation of the establishment of a service in the State Department of Health to operate such a program. He suggested the establishment of an Interdepartmental Health Council for the purpose of coordination of departments in problems or activities pertaining to health.

Physical Medicine Congress

The American Congress of Physical Medicine will hold its 24th annual scientific and clinical session, September 4 through 7 at the Hotel Pennsylvania in New York City. All sessions will be open to members of the medical profession in good standing with the American Medical Association. Additional information concerning the meeting can be obtained from the Congress office at 30 N. Michigan Avenue, Chicago 2.

Cincinnati—Dr. A. L. Schwartz has been elected president of the Cincinnati Society of Anesthetists. Dr. Irwin Kaplan is vice-president, and Dr. Bernard Safer, secretary.



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Activities of County Societies

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

CLINTON

Dr. E. Dalton Peelle of Wilmington spoke on the subject "Service in India", at the April 2 meeting of the Clinton County Medical Society.
—R. W. DeCrow, M.D., secy.

HAMILTON

A prediction that the use of human blood plasma and its numerous by-products will become an ever-increasing factor in the field of medicine within the next 5 or 10 years was made by Dr. Charles A. Janeway, Boston, in an address to the Academy of Medicine of Cincinnati, April 2, at the Academy Auditorium in Cincinnati. Dr. Janeway, who spoke on the topic, "Clinical Uses of the Products of Human Plasma Fractionation", is assistant professor of pediatrics, Harvard Medical School; senior associate in medicine at the Peter Bent Brigham Hospital; and visiting physician at the Children's Hospital, Boston.—Bulletin.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

CHAMPAIGN

With the resignation of Dr. V. G. Wolfe, Urbana, Dr. V. R. Frederick of the same city, has become president of the Champaign County Medical Society. Dr. F. R. Grogan, Urbana, has been chosen as president-elect of the organization.

CLARK

A "Symposium on Chemotherapy and Antibiotic Therapy of the Respiratory System" by Dr. Louis Mendelson, Dr. Starling Yinger, and Dr. Rudolph Pospisil, all of Springfield, was the feature of the April 18 meeting of the Clark County Medical Society at the Shawnee Hotel, Springfield. A party for physicians who recently returned from the armed forces was sponsored by the organization at the Van Dyke Club, Springfield, on April 24.—H. H. Ingling, M.D., secy.

DARKE

Dr. Samuel Flook, orthopedic surgeon of Dayton, talked on "Fractures of the Upper Extremities", at the April 16 meeting of the Darke County Medical Society held at the Wiesbusch Manor House, Greenville.—W. D. Bishop, M.D., secy.

MONTGOMERY

Members of the Montgomery County Medical Society were guests of Dr. F. G. Barr, medical director of the National Cash Register Company, Dayton, for a dinner meeting April 5 at the Administrative Building of the Company. The following program was offered: "Preventive Medicine in Industry", G. H. Collings, M.D., Sparrows Point Plant; "Some Chest Conditions in Industry", Paul J. Bamberger, M.D., Bethlehem; "Injuries of the Shoulder Joint", James M. Dziob, M.D., Lackawanna Plant; and "The Physician's Role in Industry", Loyal A. Shoudy, M.D., Medical Director, President-elect, American Association of Industrial Physicians and Surgeons.

The Dayton Divisions of the General Motors Corporation were hosts to the members of the society at a meeting April 24 in the Moraine City Plant of the Frigidaire Division. The program included a tour of the plant, dinner, and a showing of the motion picture, "Doctor in Industry", dealing with the history of the medical department of the Corporation, and its present status.

On May 3 the members will hold a dinner meeting at the Hotel Van Cleve, Dayton. Dr. M. M. Zinninger, of the University of Cincinnati Medical School, will be the guest speaker. On May 15, members will be the guests of the medical staff at Patterson Field, with golf, dinner, and program on the afternoon schedule.
—N. E. Leyda, M.D., pres.

Third District

(COUNCILOR: GUY E. NOBLE, M.D., ST. MARYS)

ALLEN

"Allergy" and "Soil and Our Health" were the two general topics discussed by Dr. Jonathan Forman, editor of *The Journal*, at the March 19 meeting of the Academy of Medicine of Lima and Allen County.—H. H. Brueckner, M. D., Secy.

Fourth District

(COUNCILOR: A. A. BRINDLEY, M.D., TOLEDO)

LUCAS

Topic for the general meeting of the Academy of Medicine of Toledo and Lucas County, held April 5 at the Academy Building, was "Recent Developments in Certain Rickettsial Diseases", with Colonel Joseph F. Sadusk, Jr., M.C., A.U.S., Washington, D.C., as guest speaker.

April 12—Section of Pathology, Experimental Medicine and Bacteriology: "The Laboratory Diagnosis of Tuberculosis", Dr. C. E. Woodruff, pathologist and director, Laboratory of Maybury Sanatorium, Northville, Michigan.

April 26—Surgical Section: "Anoxemia in Anesthesia", Dr. J. A. Radecki, Toledo.—Bulletin.

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

ASHTABULA

Dr. Elmer Hess, of Erie, Pennsylvania, addressed the members of the Ashtabula County

Medical Society on the topic, "Urological Problems and General Practice", during the March 12 meeting at the Hotel Ashtabula.—News clipping.

CUYAHOGA

At a special meeting in cooperation with the School of Medicine of Western Reserve University and the Division of Health of Cleveland, April 30 in the Medical Library Auditorium, the Academy of Medicine of Cleveland heard Dr. N. J. Eastman, professor of obstetrics, Johns Hopkins University School of Medicine, speak on "Prematurity from the Obstetrical Standpoint", and Dr. J. L. Wilson, professor of pediatrics, University of Michigan School of Medicine, discuss "The Care of the Premature Infant". The meeting was one of the main events of the three-day refresher course program in Cleveland.

April 5—Clinical and Pathological Section, Herrick Room, Medical Library: "Bilateral Prefrontal Lobotomy", Drs. H. A. Lipson, E. H. Crawfis, E. W. Shannon, J. M. Whitworth. "The Relation of Folic Acid to Macrocytic Anemias", Drs. R. W. Heinle and A. D. Welch. "The Paraplegic Patient: Problems of Convalescence, Care, and Rehabilitation", Dr. C. W. Elkins.

April 12—Combined Meeting, Experimental Medicine Section of the Academy of Medicine and the Cleveland Section of the Society for Experimental Biology and Medicine, Institute of Pathology Amphitheater: "Histamine Antagonists and Histamine Immunity in Relation to the Histamine Theory of Allergy", Drs. M. B. Cohen, Harold Friedman, Jon Zonis, and Thomas Genatios. "Cordiolipin Antigen in the Microscopic Slide Precipitation Test for Syphilis", Dr. Benjamin Kline. "The Crystallization of a Toxic Protein from Clostridium Tetani Filtrates which Appears to be Identical with Tetanal Toxin", Louis Pillemer, Ph.D. and Ruth G. Wittler, M.S. "Immunological Properties of Urinary Proteins", E. E. Ecker, Ph.D., and Sam Seifter, Ph.D.

April 17—Obstetrical and Gynecological Section, Herrick Room, Medical Library: "Hystero salpingography—A Therapeutic and Diagnostic Gynecologic Procedure", Dr. Clifford J. Vogt. "The Puerperal Endometrium—A Study of Endometrial Biopsy Six to Eight Weeks Postpartum", Dr. M. B. Laven and Dr. Anna M. Young.—Bulletin.

Sixth District

(COUNCILOR: R. L. RUTLEDGE, M.D., ALLIANCE)

COLUMBIANA

Dr. L. W. King, Salem, was the speaker for the March meeting of the Columbiana County Medical Society, held at the Lape Hotel in Salem. Dr. King discussed observations of eye, ear, nose, and throat treatment.—News clipping.

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PORTAGE

Dr. Iola Sivon, instructor in allergies and pediatrics at the Ohio State University College of Medicine, spoke on "Allergies and Allergens", at the April 4 meeting of the Portage County Medical Society, held at Robinson Memorial Hospital, Ravenna.—E. J. Widdecombe, M.D., secy.

SUMMIT

Members of the Summit County Medical Society heard Dr. Robert L. Faulkner, assistant professor of gynecology, Western Reserve University School of Medicine, talk on the subject "Vaginal Discharges" at the April 2 meeting, held in the Nurses' Home, City Hospital, Akron.—Bulletin.

TRUMBULL

The Trumbull County Medical Society held its March 21 meeting at the Warner Hotel, Warren, with Dr. Robert Stecher, Cleveland City Hospital, as speaker. Dr. Stecher talked on "Arthritis and Rheumatism", using lantern slides for illustration.

Members of the Mahoning and Trumbull county medical societies were guests of the General Motors Club of Warren and Youngstown March 28. The movie, "Doctor in Industry" was shown, preceded by a dinner.—News clipping.

Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

BELMONT

The Martins Ferry Hospital was host to the Belmont County Medical Association at a dinner March 7. Dr. J. B. Martin, St. Clairsville, president of the society, presided at the session which was the first meeting of 1946.—News clipping.

JEFFERSON

Dr. Marion Black, Cleveland, member of the gynecology staff at Western Reserve University School of Medicine, addressed the members of the Jefferson County Medical Society March 19 at the Ohio Valley Hospital. He spoke on "Leukorrhea". Dr. Black served overseas with Dr. Howard Brettell, Steubenville, president of the Jefferson County Society.—News clipping.

TUSCARAWAS

The Tuscarawas County Medical Society and Woman's Auxiliary held a banquet in honor of members who have returned from the armed services March 13 at the Union Country Club,

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New Philadelphia. War pictures taken by the returned veterans were shown.—News clipping.

Eighth District

(COUNCILOR: GEORGE F. SWAN, M.D., CAMBRIDGE)

LICKING

The Licking County Medical Society met April 2 for a dinner at the Granville Inn, Granville, with presidents, secretaries, and delegates of the Eighth District as guests.—News clipping.

MUSKINGUM

Dr. Harrison Evans, Columbus psychiatrist, spoke at the April 3 meeting of the Muskingum County Academy of Medicine, held at the University Club in Zanesville.—Beatrice T. Hagen, M.D., secy.

PERRY

The Perry County Medical Society held a luncheon meeting at the Park Hotel, New Lexington, March 28.

Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

SCIOTO

Dr. Karl P. Klassen, Columbus, spoke on "Surgery of the Suppurative Diseases of the Chest", at the meeting of the Hempstead Academy of Medicine March 9, in the nurses' home of Portsmouth General Hospital.—News clipping.

JACKSON

Newly elected officers of the Jackson County Medical Society are: Dr. John L. Frazer, Wellston, pres.; Dr. C. C. Fitzpatrick, Jackson, pres.-elect; Dr. W. B. Taylor, Jackson, secy.-treas.

Tenth District

(COUNCILOR: H. M. CLODFELTER, M.D., COLUMBUS)

FRANKLIN

Irvine H. Page, M.D., director of research, Cleveland Clinic, spoke on "Recent Advances in the Knowledge of Hypertension" at the April 1 meeting of the Columbus Academy of Medicine, held at the Art Gallery, Columbus. At the April 15 meeting, held at the same place, Dr. Allen C. Barnes, associate professor of obstetrics and gynecology, Ohio State University College of Medicine, talked on "The Bloody Complications of Obstetrics".—Bulletin.

Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

LORAIN

Dr. Harry G. Sloan, Cleveland, addressed the April 9 meeting of the Lorain County Medical Society on the subject "Tumors of the Breast". At the business session, the members discussed the proposed increase in Ohio State Medical Association dues. The meeting was held at Castle-on-the-Lake, Lorain.—L. H. Trufant, M.D., secy.

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Do You Know - - -

New officers of the Alumni of the Ohio State University College of Medicine are: Dr. Robert C. Austin, '13, Dayton, president; Dr. William L. Skipp, '18, Youngstown, first vice-president; Dr. Alfred A. Whittaker, '18, Detroit, second vice-president; Dr. Jonathan Forman, '13, Columbus, editor and historian; Dr. Russel G. Means, '19, Columbus, secretary; John B. Fullen, '25, executive secretary, Ohio State University Alumni Association. They were elected during the Ninth Post-Collegiate Assembly held at the College of Medicine, March 27.

* * *

At the recent annual conference of the Ohio Society, Daughters of the American Revolution, in Cincinnati, a report of the Special Legislative Committee was adopted, condemning current proposals to socialize the medical profession.

* * *

Dr. L. Howard Schriver, Cincinnati, President of the Ohio State Medical Association, represented the medical profession on a health discussion on radio station WLW's Sunday Farm Hour, recently. He also addressed the Cincinnati General Motors Club on "Political Medicine".

* * *

Eight American scientists received Borden Awards of a gold medal and $1,000, for outstanding contributions to scientific research in the food industry and related fields during 1945. This brings to 47 the total number of awards made since their establishment by the Borden Company in 1936. Designed to recognize and encourage outstanding research achievements, the awards are administered by seven professional and scientific associations. These are: The American Chemical Society; American Dairy Science Association; American Home Economics Association; American Institute of Nutrition; American Academy of Pediatrics; Poultry Science Association; and The American Veterinary Medical Association.

* * *

Dr. Harland G. Wood, associate professor of physiological chemistry, University of Minnesota, will head the department of biochemistry, Western Reserve University, which recently received a $500,000 gift from the Elisabeth Severence Prentiss Foundation for expanding its operations. He will succeed Dr. Victor C. Myers, who has been named head of the newly created department of clinical biochemistry at the School of Medicine. In 1941, Dr. Wood won the annual Eli Lilly award for his work in the biochemistry of bacteria.

Dr. Jonathan Forman, Columbus, spoke on "Influence of Soil on Human Health", at a joint dinner session of the Friends of the Land and American Planning and Civic Association, April 24, at Dallas, Texas. Dr. Forman is vice-president of Friends of the Land. On the same trip, he addressed the Tulsa Kiwanis Club, and forums at Oklahoma City, Dallas, Temple, and Austin, Texas.

* * *

Dr. Arthur T. Hopwood, superintendent of the State Institution for the Feeble-Minded at Apple Creek since 1941, has been selected to head the hospital for mental patients which the state hopes to establish at the former Fletcher General Hospital, Cambridge.

* * *

Under the direction of its public relations committee, the Jefferson County Medical Society is sponsoring a series of radio health education programs, the first and third Thursdays of each month, from 9:30 to 10:00 P.M. over radio station WSTV, Steubenville.

* * *

George H. Saville, director of public relations for the Ohio State Medical Association, told the members of the Preble County Rotary Club at Eaton, April 8, that the constructive program of the medical profession offers the public a more practical solution for the problem of better distribution of medical care than the Wagner-Murray-Dingell and Pepper bills. He also addressed the resident staff of University Hospital, Columbus, April 25.

* * *

Dr. George M. Curtis, chairman of the department of surgical research, Ohio State University College of Medicine, was named president-elect of the Central Surgical Association at the annual meeting of that group in Chicago.

* * *

Dr. Martin Henry Fischer, research worker and member of the faculty of the University of Cincinnati College of Medicine, received the 1946 Award of Merit from the Miami Valley Chapter of the American Institute of Chemists.

* * *

In the first six weeks of the operation of Public Law 293, which created the new Department of Medicine and Surgery of the Veterans Administration, 797 new physicians accepted appointment to the V.A., including 57 specialists certified by one or more of the approving boards. Approximately 150 residents are now in training, and the Veterans Administration hopes to have 750 residents in training within four months.

WOMAN'S AUXILIARY NEWS

BY MRS. FRED W. BROSIUS, MIDDLETOWN
Chairman, Publicity Committee

BUTLER COUNTY

A combined dinner meeting of the Butler County Medical Society, its auxiliary, and the Union District Medical Association was held April 24 at the Manchester Hotel, Hamilton. Preceding the dinner, Dr. Earl H. Baxter, Columbus, addressed the medical group on "Common Sense Pediatrics". Dr. Russell Malcolm, Richmond, Indiana, entertained the assembly with some colored pictures taken when he served with Patton's Army in France.

Guest speaker at the dinner was Dr. John Mitchell, Columbus, who chose "Allergy" as his subject.

The tables were elaborately decorated with spring flowers, and an orchestra provided music throughout the evening. Mrs. Walter H. Roehll was chairman of arrangements. Mrs. Fred Brosius as Auxiliary president conducted a brief business session for election of officers prior to the dinner.

FRANKLIN COUNTY

Major John Guenther, member of the editorial staff of the *Columbus Dispatch*, and former aide to Maj. Gen. Robert S. Beightler, spoke at the April 15 meeting of the Woman's Auxiliary to the Columbus Academy of Medicine. The meeting was held at the home of Dr. and Mrs. A. W. Troutman. Major Guenther's subject was "A Veteran's Plea for Realism". During 43 months of continuous oveseas duty, he participated in all campaigns of the 37th Division and holds the Silver Star, Bronze Star with cluster, and the Purple Heart.

SCIOTO COUNTY

Members of the Woman's Auxiliary to the Hempstead Academy of Medicine convened at the home of Mrs. J. W. Daehler, Portsmouth, for the March meeting. Dr. G. E. Neff, Portsmouth, related his experiences while stationed at front line hospitals in the European Theater of Operations. During the afternoon the members prepared dressings for the Mercy hospital and the hostess served tea with the assistance of Mrs. George Obrist and Mrs. Walter Braunlin.—Mrs. W. G. Cheney, publicity chairman.

SUMMIT COUNTY

Summit County is very proud to pay tribute to Mrs. Paul A. Davis, who will take office as President of the Auxiliary to the Ohio State Medical Association this month. It is the first time in history that we have had a president chosen to the State Auxiliary from Summit County. Mrs. Davis has worked untiringly in

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GYNECOLOGY—Two Weeks Intensive Course starting September 23.
One Week Personal Course in Vaginal Approach to Pelvic Surgery starting June 10 and September 16.

OBSTETRICS—Two Weeks Intensive Course starting September 9.

MEDICINE—Two Weeks Intensive Course starting May 13 and June 17.

ELECTROCARDIOGRAPHY & HEART DISEASE—Two Weeks Intensive Course starting August 5.

GASTROSCOPY & GASTROENTEROLOGY — Two Weeks Personal Course June 3.

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the Auxiliary and she is very capable and a fine leader. She has shown in the past that she is both efficient and dependable, consequently the State Auxiliary will continue to grow and prosper under her leadership.

Because of the Lenten Season and conflicting dates, it was necessary to postpone the dinner dance scheduled for April by the Summit County Auxiliary. Mrs. R. M. Lemmon, chairman of the public relations, and Mrs. W. A. Keitzer, chairman of the telephone committee, have been very busy this month. Two hundred and fifty letters, enclosing the "Do you know" pamphlets were mailed to the Auxiliary membership, to presidents of many women's organizations, and to numerous men's groups.

The Auxiliary will hold the last meeting of the year on May 14 at the Women's City Club. After luncheon, the annual reports of committees will be given and the election of officers. At this meeting the membership will be asked to vote upon the proposed project of the girls' class at Leggett School, where girls are sent by the Court for occupational training. The principal, Miss Dorthea Derring, has invited a committee to a lunch prepared and served by the girls.

The new officers will assume office immediately after election. Mrs. D. M. Traul, president-elect, has proven herself most competent and efficient. The years she has given to Auxiliary work have proven her ability to promote the objectives of the Summit County Medical Auxiliary.—Reported by Mrs. C. F. Wharton, 135 Mayfield Ave., Akron, Ohio.

TRUMBULL COUNTY

Officers of the Trumbull County Woman's Auxiliary for 1946, are, Mrs. David Beers, president; Mrs. Allen Beale, vice-president; Mrs. Aubrey Sparks, secretary; Mrs. Royal Dobbins, treasurer. This auxiliary was reorganized last fall, and since that time has engaged in a Polish War Relief Drive for medical materials, and has had a program devoted to cancer prevention.

Harry V. Knoor, Ph.D., Antioch College, research physicist, has been appointed director of the Charles F. Kettering Foundation for the study of chlorophyll and photosynthesis.

Cincinnati—Dr. Elmer A. Schlueter, Cincinnati, has been named president of the medical staff of St. Mary's Hospital, located in that city, according to a recent announcement.

Columbus—Dr. Jonathan Forman, Columbus, editor of *The Journal*, spoke on the subject "How Medicine Began in Ohio" at the March 11 meeting of the Columbus Rotary Club.

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Buckeye News Notes

Ashtabula—Dr. William H. Eberle, who served in the Army Medical Corps during the war, described two Pacific islands upon which he was stationed during the February 27 meeting of the Ashtabula Exchange club.

Athens—Dr. Eileen Phillips, who received premedical training at Ohio University and subsequently attended the Ohio State University College of Medicine, has returned to Ohio University to serve as assistant health director of that institution.

Bluffton—Dr. M. R. Bixel has been elected vice-president of the Allen County Board of Health.

Cincinnati—Dr. Frank H. Mayfield, director of neurosurgery in four local hospitals, has been named regional consultant in neurosurgery for the Cincinnati Area by the Veterans' Administration.

Cincinnati—Dr. Ralph Zucker, recently released from the Army Medical Corps, has been appointed as chief clinician of the Baby Milk Association, Cincinnati.

Cleveland—Dr. Harry Goldblatt, professor of experimental pathology and associate director of the Institute of Pathology, Western Reserve University, spoke on "Experimental Cirrhosis of the Liver" at 8 p.m. May 2 in the Institute of Pathology Amphitheater. This is the first of a series of annual lectures sponsored by Phi Delta Epsilon, national medical fraternity.

Cleveland—Dr. Louis J. Karnosh, Cleveland, was elected president of the Western Reserve University Medical School Alumni Association at its 73rd annual banquet in Cleveland March 14.

Columbus—Dr. N. Paul Hudson, chairman of the department of bacteriology at the Ohio State University, has been selected to succeed Alpheus W. Smith, Ph.D., as dean of the university's graduate school.

Delphos—According to a newspaper report, Dr. Ezra Burnett is beginning his 54th year of practice in this community.

Fostoria—Dr. T. W. Geoghegan, recently returned from service as a Naval medical officer, has been chosen as chief of staff of the Fostoria City Hospital for the year 1946.

Franklin—Four Franklin physicians have asked the village council to recommend enactment of legislation to provide a sanitary code for that municipality.

Owensville—Dr. Allen B. Rapp, who has practiced medicine here for 35 years, has been named coroner of Clermont County.

Pataskala—Dr. R. C. Haubrich has been elected to a five year term of office on the Licking County Board of Health.

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Rulings of Attorney-General

Among opinions recently rendered by Attorney General Hugh S. Jenkins are several of interest to the medical profession. The syllabi follow:

No. 790—A county tuberculosis hospital may contract for the services of consulting physicians to be paid upon a fee basis for services performed. Such contractual service is not subject to the laws regulating the civil service of the counties.

No. 796—The duly constituted officers of a municipality having charge of the operation of a hospital belonging to such municipality have authority to enter into a contract with a nonprofit hospital service corporation organized under Sec. 669 *et seq.*, G.C., for the care in such hospital of subscribers to such service corporation, to be paid for by such corporation. (Opinion No. 1919 renderd February 26, 1940, modified.) Rates to be charged for such service should be the same as those charged other patients for like service.

Psychiatrists To Discuss Problems of Veterans and Workers

The problem of the returning veteran, his rehabilitation and readjustment to civilian life will be a predominant theme of the four-day convention of the American Psychiatric Association, opening at Chicago's Palmer House on May 27.

Top officials of the Veterans Administration and of the United States Public Health Service will meet in special sections with psychiatrists from all parts of the country to discuss their common responsibility in aiding the mental and physical "reconversion" of ex-service men.

The growing importance of psychiatry in industry will be considered in a section dealing with the job relationships of "well" persons, in addition to those with mental illnesses and maladjusted workers.

Lisbon—The Columbiana County Advisory Council of the county board of health voted March 4 for the employment of a full-time county health commissioner at a salary of $5,000 annually.

Ravenna—Dr. Max Sternlieb, recently released from the Army Medical Corps, has assumed the duties of Portage County Health Commissioner. He is a native of Cleveland, and formerly practiced in Wadsworth.

Wadsworth—Dr. E. J. Koontz celebrated his 50th anniversary as a practicing physician in this community, March 26.

CLASSIFIED ADVERTISEMENTS

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JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.*

GEORGE H. SAVILLE, *Asst. Managing Editor*

HART F. PAGE, *News Editor*

Public Health and the Treatment of Early Syphilis

ROY L. KILE, M.D.

TREMENDOUS changes have occurred in the management of syphilis in recent years. Routine weekly treatment with arsenicals and bismuth is still as reliable as ever. However, a large percentage of patients never complete this method of therapy, especially the type of patient seen in the clinic. Various forms of "rapid" treatment overcome this obstacle if administered under hospitalization. Those forms of "rapid" treatment not requiring hospitalization still have this objection. The triweekly course of arsenical as recommended by Eagle when given on an out-patient basis often has a high rate of lapsed cases. A schedule suggested by Thomas and Wexler employing a 10 day routine has been found effective. It consists of giving an injection of mapharsen every day for 10 days. Every other day a bout of fever is induced by giving typhoid vaccine intravenously for a total of four bouts and on alternate days an injection of bismuth is given. Thus the schedule is 10-4-4. Using this routine one can expect about 80 to 85 per cent cures for early syphilis. Many other schedules of treatment have been recommended and some are equally effective.

Any schedule of treatment using an arsenical drug runs the risk of reactions. Dermatitis, gastro-intestinal upsets, and occasionally encephalopathy and death may ensue. With the introduction of penicillin a few years ago an effective spirochetocidal agent was found in which reactions were reduced to a minimum. Only very rarely has it been necessary to discontinue treatment due to reactions from penicillin. **It is to be emphasized however, that the optimum time, method of administration, and dosage or combination of drugs with penicillin for syphilotherapy is still unknown.** Studies are being conducted which should give us more accurate data on this problem but it is still not settled.

If penicillin in aqueous solution is employed, it must be given at least every three hours day and night. The total dose must exceed 1,200,000 units and better 2,400,000 units over 8 to 10 days' time. Various combinations of penicillin, arsenicals, and bismuth have been tried. Whenever these two drugs are added to the schedule, the incidence of reactions increases. A schedule of 1,200,000 units of penicillin with five injections of arsenical (mapharsen or clorarsen) and three of bismuth over 7½ days' time has been found very good. This must be done while the patient is hospitalized, and is commonly referred to as the 12-5-3 schedule. Many patients have been treated with this routine in the various Rapid Treatment Centers.

Giving penicillin in aqueous solution at longer than 3-hour intervals between injections or any

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The Author

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schedule that is not given continuously until completed will be found less effective and should not be employed in the treatment of syphilis. Adequate amounts of the drug must also be used, but at the present time the exact amount is unknown. Combinations with other known anti-syphilitic drugs can be effectively employed.

OHIO CODE

Obviously early syphilis cases, for which the above schedules have been used, are by far the most important from the public health standpoint. Any physician who treats early syphilis incurs certain public health responsibilities by undertaking such treatment. Many physicians have for years been cognizant of these responsibilities just as is the case with any other communicable disease or one that has potentialities of becoming communicable. Unfortunately others have never assumed them even though it is required by the Ohio Sanitary Code.

Obviously a patient with syphilis must have acquired it from someone who also has the disease. As a result it is necessary that the contacts of the syphilitic patient be investigated. While the relationships of the physician and patient are confidential, this factor is less important than the responsibility of finding those whom the patient may have infected or by whom he was infected. This responsibility rests with the physician, or with the health department from whom he may have requested epidemiological assistance. By explaining to the patient how the disease is spread and the consequences of untreated syphilis, in just a few minutes the physician can usually elicit the names of contacts. Many people are quite happy to assist in breaking the chain of infection, particularly if it is understood that the source of the information is kept confidential. At times patients will even bring in their own contacts; or the local health department will gladly see that they get into a physician's office or any other source of treatment they desire. Physicians do not use these facilities as they should and have far too long been reluctant to assume this responsibility.

CASE REPORTING

In one large city health department of Ohio, physicians report five or six contacts a year while clinics report hundreds. It is an opportunity to demonstrate an interest in preventive medicine that has heretofore been regrettably neglected. Health Departments are happy to work with the physician on these matters. This is the most efficient means of case finding and of preventing the spread of this disease.

Reporting venereal disease cases by physicians to health departments has always been a responsibility that has not been properly assumed, even though it is required by law. Forms for reporting can be obtained from the health department, are brief, and can be readily completed. Syphilis is being reported much better in recent years than heretofore, but many very competent physicians are still not assuming this responsibility. All venereal disease records are held confidential in health departments just as they should be everywhere. Reporting cases gives statistics as to incidence, etc., and is important, but it is my belief that the assistance in finding contacts or transmitting information on contacts to the health department is much more important in controlling the venereal diseases.

The cooperation of the physician in the control program not only helps find cases but also shows the community that the physicians are interested. When the confidential nature of the information is explained, in most instances, the patient himself will appreciate the physician's interest in helping prevent both the spread and the late sequela of venereal diseases.

Many men are being separated from the armed forces with doubtful or positive blood tests for syphilis and referred back to their local health departments. Approximately 50 per cent of these men and women on further examination are found **not** to have syphilis. One must, therefore, be very cautious of diagnosing syphilis in this group. Some have malaria and other diseases that produce false positive reactions. Others have only doubtful serologic tests on separation. Physicians seeing these cases should have several tests, preferably in different laboratories, and quantitative reports if possible before reaching a conclusion as to whether the separatee has syphilis. Unless great care is observed, many non-syphilitics will be started on treatment.

SUMMARY

By better case finding, case reporting, and health education on the part of private physicians and health departments, it will be possible to make the most of the excellent new treatment drugs and methods which are now available.

Massive Hemorrhage

A major obstacle in evaluating both mortality and treatment is the difficulty in determining when gastrointestinal bleeding may be considered massive and consequently a threat to the life of the patient. The quantity of blood being lost is often concealed by retention within the lumen of the gastrointestinal tract. The red cell count may be misleading because it tells nothing of the rate of bleeding, particularly before hemodilution has occurred.—Daniel M. Green, M.D., Seattle, Wash.; Northwest Med., Vol. 45, No. 5, May, 1946.

Relapse During Penicillin Therapy of Syphilis

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ONE of the most trustworthy methods of evaluating a drug used for syphilotherapy is to observe the frequency of relapse. Relapse varies in character. Thus serologic relapse, for the purposes of this paper, is a definite rise in serum titer on three repeat occasions in absence of clinical symptoms. In clinical relapse only, there are definite clinical symptoms, usually darkfield positive and without change in serologic titer. A serologic titer remaining fixed is considered as serology persistent. One may encounter a monorecidive, a muco-cutaneous relapse, a generalized eruption, an osseous relapse, a central nervous system neurologic relapse, congenital syphilis relapse, and relapse of various internal organs. The Cooperative Group have shown that most cases of relapse will occur within the first two years of treatment, in fact a large percentage will occur within the first year of treatment and within the first six months after treatment is stopped.

It has already been pointed out that with heavy metal therapy of syphilis there are so-called chronic relapsers, the same, as will be discussed later, is also true of penicillin therapy.

The first work with acute syphilis was done in October, 1943, with a small group of 5 male patients at the University Hospital using a dosage suggested by Prof. Jos. T. Wearn of 1,200,000 units—400,000 units by intravenous drip the first 48 hours and followed by 20,000 units intramuscularly every three hours for 5 days. With 5 female patients, 20,000 units were given intramuscuarly every two hours for 7½ days—total dosage likewise 1,200,000 units. The last case was treated November 10, 1943, and while 6 have disappeared, 3 have been well for one year or longer, and 1 for over 2 years. The penicillin used in these cases was crude, not the refined variety now in use and as far as is known there were no relapses in the group.

This study is confined to 730 cases treated with various dosages of penicillin, omitting cases of syphilis of the central nervous system.

These cases of acute syphilis are made up as follows from the standpoint of penicillin dosage:

TABLE I

Group	Dosage	Number
I	60,000 units (1,000 units every 3 hours for 7½ days)	31
IA	60,000 " (same dosage plus mapharsen 0.04 every other day for 8 doses)	47
II	300,000 " (5,000 units every 3 hours for 7½ days)	81
IV	1,200,000 " (400,000 intravenous drip first 48 hours followed by 20,000 units intramuscularly every 3 hours for 5 days) (males)	5
	(20,000 units intramuscularly every 2 hours for 5 days (females)	5
VA	1,200,000 " (20,000 units every 3 hours for 7½ days)	8
B	1,200,000 " (40,000 units every 6 hours for 7½ days)	129
VI	2,400,000 " (20,000 units every 3 hours for 15 days)	54
VII	1,600,000 " (20,000 units every 3 hours for 10 days)	369
VIII	2,000,000 " (40,000 units every 6 hours for 12½ days)	1
	Total	730

The appended chart shows the number of patients treated with the various dosage forms, total number of failures from the use of penicillin, and the types of failures. Serologic relapses, 51 of them, were naturally the commonest type of failure and it is for that reason that the titrated serologic test is so necessary in the treatment

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The results which have been presented in this paper must be interpreted in light of the fact that from June. 1943, the date of inception of the study, to the present, commercial penicillin has been a changing mixture of various substances. The content of "impurities" has gradually decreased as potency, in terms of units per mgm., has increased. The relative amounts of the several identified penicillin fractions C, F, X, and K, have likewise varied from time to time. Those two changes, and perhaps others, suggest that therapeutic efficacy may not have remained constant; and that it may be significantly different today than it was originally. It is not now possible to assess the extent to which these changes may have affected the results here reported.

of the syphilitic. The trend of the serologic curve is of great value to the physician in detecting rise or fall in units and even in predicting a clinical relapse. Given a titration rising up to 64 or 128 units roughly (16 to 32 Kahn units) the clinician may look for relapse clinical in type as well as serologic. The type of serologic test done at the University Hospital and at the Cleveland City Hospital is described in another paper. (Cole, H. N., et al. "The Use of Penicillin in the Treatment of Syphilis in Pregnancy.")

TABLE II

Relapse in Acute Syphilis Treated with Pencillin

	Dosage	Number of Cases	Treatment Failures	Sero Relapses	Clinical Relapses	Sero and Clinical Relapses	Neuro Relapses	Serologically and Clinically Well: Less than 1 Yr.	Serologically and Clinically Well: Over 1 Yr.
I	60,000 units 1,000 q3h	31	13	6		2	5	2	1
IA	60,000 units intramuscularly plus 320 mgs. mapharsen, intravenously	47	16	3	1	10	2	4	4
II	300,000 units 5,000 q3h	81	26	10	2	9	5	4	8
IV	1,200,000 units 400,000 intravenous drip plus 800,000 intramuscularly	5	0			(1 over 2 yrs.)			2
	1,200,000 units 20,000 q2h	5	0						1
VA	1,200,000 units 20,000 q3h	8	2	2		0	0	1	1
B	1,200,000 units 40,000 q6h	129	24	12		12	0	26	15
VI	2,400,000 units 20,000 q3h	54	2		1	1		16	
VII	1,600,000 units 20,000 q3h	369	27	18		9		69	
VIII	2,000,000 units 40,000 q6h	1							
	Total	730	110	51	4	43	12	122	32

In the above list of relapses are not included the birth of a syphilitic child with cutaneous lesions and meningitis after 300,000 units, a still birth, possibly syphilitic after 2,400,00 units, and a macerated fetus at 7 months, 247 days after the same dosage—undoubtedly syphilitic.

Roughly, 4 units of titer correspond to 1 Kahn unit.

The next most common type of relapse was serological and clinical. This type of relapse was mucocutaneous with lesions on the genitalia and in the mouth as well as on the skin. In severe cases extensive condylomata lata would often be found. Occasionally there would be a recurring generalized syphiloderm, rarely annular papular lesions around the mouth, nares and over the chin. Naturally with the mucocutaneous lesions positive darkfield examinations were most helpful in confirming the clinical diagnosis. By "clinical relapse" is meant the cutaneous or muccocutaneous recurrence in the patient whose serologic titration has not changed materially either up or down. The neurologic relapse was, of course, the most serious type encountered and was usually asymptomatic in character, only being detected by a repeat lumbar puncture on readmittance of the patient into the hospital. A few illustrations may be useful to bring out the salient characteristics of the various types.

SEROLOGICAL AND CLINICAL RELAPSE

Case 1. Eva G., aged 20. Diagnosis: Early genital primary, darkfield positive on examination. She received 60,000 units sodium penicillin from November 20 to December 3, 1943.

Table of Serologic Titers

12- 9-43	20 units (5 Kahn units)
3-16-44	Seronegative and clinically well.
5-11-44	Seronegative and clinically well.
9-21-44	160 units (40 Kahn units)
10-19-44	Serologic and clinical relapse with mucus patches.

Patient retreated with sodium penicillin, 1,200,000 units, 40,000 every 6 hours, from October 19 to October 27, 1944.

11-28-44	20 units
12-28-44	20 "
3- 1-45	1 "
4- 5-45	1 "
6-28-45	Seronegative and clinically well.

Naturally, this patient should be followed for at least one year after she is clinically and serologically entirely well.

SEROLOGIC PERSISTENCE (NEUROLOGIC RELAPSE ASYMPTOMATIC IN TYPE)

Case 2. Louise S., aged 26. Diagnosis: Early syphilis cutaneous. She was treated with 60,000 units penicillin from November 16 to November 26, 1943. The serologic titer in the beginning was 80 units (20 Kahn) then dropped to 40 units (10 Kahn) and continued at that level for four different monthly examinations. She was hospitalized and lumbar puncture revealed a spinal fluid with 38 lymphocytes, positive Ross Jones, gum mastic 2,210,000,000, total protein 36.4 mgs. per cent, Wassermann negative in 0.1 cc. and four plus in 0.5 and 1.0 cc. She was retreated with 2,000,000 units sodium penicillin and lumbar puncture on January 11, 1945, showed 2 cells, a positive Ross Jones, a normal gum mastic, total protein 22.7 mgs. per cent, and Wassermann completely negative even with 1 cc. of spinal fluid.

Subsequent Serologies

5- 2-44	40 units
7-21-44	1 "
10-27-44	10 "
1-11-45	Wassermann— Kline Diag.+ Excl.+
4- 2-45	Wassermann— Kline Diag.+ Excl.+

This patient must be followed further and she should have another lumbar puncture immediately.

The type of individual that gives the most difficulty is the early case of syphilis, perhaps with a primary lesion and diagnosed by darkfield examination, with serology showing a low titer and yet positive in character. Diagnosis of syphilis primary, early, is made and penicillin administered. The lesion disappears rapidly. The serologic reaction returns to negative and within a few months the patient returns with a new lesion, on a new site on the genitalia and again showing a positive darkfield on examination. Should this be diagnosed as monorecidive relapse or is it perhaps a reinfection? To give an example which some might interpret as a chronic relapser:

Case 3. John H., aged 24. History of secondary syphilis in the Army and given 40 mapharsen and 16 bismuth injections. First admission at Cleveland City Hospital from January 17 to February 10, 1944, statistically reported as syphilis secondary, relapse. The patient had been exposed to a patient of the City Hospital clinic having extensive condylomata lata. There was a typical primary lesion just behind the glans on the dorsum of the penis, having a raised cartilaginous border and characteristic lymph node reaction of primary syphilis. He had a generalized eruption and numerous moist papules. He was treated with the Thomas-Wexler technique, combined mapharsen, bismuth, and four hyperpyrexial reactions from typhoid para-typhoid over a 10-day period. His serologic titer was 1:16 and rose to 1:128 after treatment only to fall to 1:16 by March 8 and 1:2 (negative) by May 12.

He was readmitted on May 22 with a dirty ulcer on the dorsum of the penis and several smaller lesions which he had treated with copper sulfate. Repeated darkfield examinations were negative, serologic titer 1:128. There was a history of repeated sexual exposures. He was given penicillin, 600,000 units, and had a typical Herxheimer reaction and local edema of the tissues. The lesions healed completely. His serologic titer rose to 1:256, then dropped to 1:128 and June 28, 1944, to 1:64. He was readmitted July 20, 1944, with a fine preputial ulcer which developed two weeks after the last exposure—it was of 10 days' duration. Numerous spirochaetae were found and his serologic titer was 1:8. He was given sodium penicillin, 1,200,000 units, (40,000 every 6 hours for 7½ days) and the process healed entirely. His titer was 1:16 on July 31, 1944. The patient was delinquent until March 7, 1945, at which time his titer was negative, Kline diagnostic and exclusion one plus and Wassermann negative. On April 16, 1945, the patient re-entered the hospital with history of frequent exposures and showing multiple papules on the glans and phimotic foreskin. The darkfield examination was positive, serologic titer 1:8 which rose to 1:16 with four plus Kline diagnostic and exclusion tests, during administration of 9,000,000 units of sodium penicillin. Patient had since moved and was reported to the Division of Health as "Lost" on September 5, 1945.

Is this man an example of a chronic relapser or of reinfections? More and more of these cases are being seen since the use of intensive therapy and particularly of penicillin.

MONORECIDIVE, RELAPSE VERSUS REINFECTION

Case 4. Ivory B., aged 38. Diagnosis: Seropositive genital primary. Treated with penicillin, 60,000 units plus 320 mgs. mapharsen from March 10 to March 19, 1944.

Serologic Titers

	Wassermann
3-11-44	
3-19-44	40 units
4-24-44	1 "
5- 8-44	1 "
5-22-44	1 "

He returned to the clinic on May 22, 1944, with a single, painless, indurated lesion on the other side of the coronal sulcus which was darkfield positive on examination. Diagnosis: Clinical monorecidive relapse. He was given penicillin, 1,200,000 units, 20,000 every three hours. The lesion became darkfield negative in 48 hours but did not heal during stay in hospital. His serologic tests since, on five different occasions, are completely negative, the last one being 451 days post-therapy.

Not always is it possible, however, to have such a clear cut example and often, particularly in early marital syphilis (husband and wife), the problem of reinfection from one to the other arises or there may be a clear cut history of extra-marital exposure to a known acute syphilis. The Penicillin Panel has made it a rule that any evidence of recurrence of an acute syphilis within a year after infection should be diagnosed as relapse rather than reinfection. It is questionable whether this is always the proper diagnosis.

TIME OF RELAPSE

As with heavy metal therapy, relapses are prone to occur shortly after therapy has been discontinued. With the smaller doses of penicillin it may even occur very soon after the drug is stopped. Study of this relapse material reveals two relapses in the first month after stopping treatment, 7 in the 2nd month, 10 in the 3rd, one in the 4th, 6 in the 5th, 9 in the 6th month, and 6 in the 7th. Outside of 8 in the 10th month there was no month after the 7th with more than 3 and that was the 8th. There was one relapse in the 14th, 15th, and 16th months respectively. Of the 62 relapses noted 40, two-thirds, occurred in the first 7 months. There was one example of serologic persistence requiring treatment in the 4th month and two others, likewise, in the 4th month where there was a central nervous system involvement as well. Among the second relapses one occurred

in the 3rd month, 1 in the 6th, 1 in the 7th, 1 in the 8th, 3 in the 9th, 1 in the 10th, and 2 in the 11th months. In these second relapses, where larger doses of penicillin had been used after the first relapse, the tendency seemed to be for the relapse to occur later.

RELATION OF RELAPSE TO DOSAGE OF PENICILLIN EMPLOYED

Referring once more to the chart on relapse it shows quite clearly the preponderance of failures seen with use of 60,000 units of penicillin, even with the same amount plus 320 mgs, mapharsen, and with 300,000 units. As the dosage rises to 1,200,000 units, failures are not so frequent though still too high. The same is also true of 1,600,000 units. With 2,400,000 units there have been only two failures. With all these larger dosage forms the time is too short to bring out all the relapses that are to occur. Penicillin, while an enormous advance in syphilotherapy, must not be looked upon as a cure-all and its use requires much more careful investigation.

TREATMENT OF RELAPSE

When relapses first began to appear after penicillin therapy the practice was to retreat them with 1,200,000 units. Later, larger doses were employed, the original dose was doubled and on second relapse 9,000,000 units were used. Thus the following schedules have been carried out on the relapses:

TABLE V

1,200,000	units	35	Cases
1,600,000	"	1	"
2,000,000	"	1	"
2,400,000	"	41	"
3,600,000	"	4	"
4,000,000	"	2	"
4,800,000	"	1	"
9,000,000	"	10	"

DISCUSSION

As was mentioned earlier, relapse is one of the clinician's best means of interpreting a drug's value in the treatment of syphilis. It must be remembered that penicillin has only been used in the treatment of syphilis since 1943. An attempt has been made on a large scale by the Penicillin Panel to estimate in a short time the position of penicillin in syphilotherapy. This was particularly necessary because of venereal disease incidence in the Army and Navy. Penicillin has some very definite advantages. There are practically no serious reactions from its use. The injections are comparatively painless. The duration of the treatment is at most a week to 15 days and certainly any patient suffering from an acute syphilis should be able to spend that much time in the hospital when all the advantages are considered.

Penicillin must be looked upon as a very valuable agent in promoting public health. Moreover, it has the great superiority over heavy metal treatment of syphilis in pregnancy that, provided the child is still viable, the mother's syphilis and likewise the child's disease may be cured even up to a few days or weeks before the child is born. This was not possible with arsenical and bismuth treatment and is, therefore, probably one of the greatest advantages of this drug—this, along with its lack of severe reactions.

On the other hand, there are still a disturbing number of relapses even where comparatively large doses of penicillin are employed, e. g., 1,600,000 and 2,400,000 units. Further investigation will have to solve whether these will be prevented in the future by larger doses or by combining it with arsenical injections or with fever therapy or both. Dr. John Mahoney did a great service to humanity when he was able to show the value of penicillin in the treatment of acute syphilis.

SUMMARY

1. A report is made on the incidence of relapses, 110 in number, observed while treating 730 cases of early syphilis with varying dosages of penicillin.

2. Relapse occurs in various forms and in these cases consisted of serologic relapses most frequently, then combined serologic and clinical relapses, neurologic relapses and clinical relapses with no change in serologic titer.

3. Relapse varies with the amount of penicillin employed and is most frequent with small dosages, 60,000 units, 60,000 units plus mapharsen, 8 doses (one every other day) and with 300,000 units. There seemed to be little or no difference in the incidence of relapse with 1,200,000 units, whether 20,000 units were given every three hours or 40,000 units every six hours.

4. While the incidence of relapse is much smaller with larger doses of penicillin, yet they are high enough to be looked upon with concern, particularly when it is realized that these higher dosage forms were employed more recently and there is still plenty of time for further cases to relapse.

5. Perhaps higher dosages of penicillin should be used in the treatment of syphilis or even combinations of penicillin plus a trivalent arsenical or of penicillin plus fever therapy.

6. The use of penicillin in the treatment of syphilis is a great advance in syphilotherapy, but it must be realized that it is only a matter of three years since it has been tried out and there is still much to be known.

7. Relapse can be best predicted and controlled by vigorous follow up of cases and monthly titrated serologic tests for one year after complete reversal to a negative test.

Light for Head Mirrors

R. E. MacQUIGG, M.D., and E. E. SCHILL, R.N.

MIRROR laryngoscopy is a technique of direct concern to the general surgeon, and far less difficult than many which he masters as a matter of course, though unfortunately he is inclined to forget his introduction to the art after a few experiences with gagging patients as a student. He should not be dependent upon the laryngologist to visualize the vocal cords of his patients before thyroidectomy, for example, particularly in view of the fact that his patient may have complete paralysis of one vocal cord and yet a good speaking voice. This not only means that the margin of safety is reduced in case of malfunction, however transient, of the cord on the other side, but also means that the surgeon must assume the blame for laryngeal nerve damage which may have been none of his doing.

It is technically difficult in many patients to view the whole cord area, but it must be remembered that a glimpse of the posterior half is sufficient to establish motility and symmetry. The surgeon may ascertain this for himself without subjecting his patient to the fee of the laryngologist just as he should be able to do routine pulmonary auscultation without constant resort to an internist. In any case, preoperative check of the larynx is sound routine policy. Laryngoscopy is a useful technique not only for foreign body removal in emergencies but for lipiodolization or tracheal anesthesia before intubation. Facility with the head mirror should be acquired by those dealing with oral tumors or intercurrent lesions of ear, nose, and mouth.

The difficulty in arranging satisfactory illumination for head mirrors in general and in bedside use has led to the substitution of various direct lamps for the mirror, or even to use of a small lamp fastened before the head mirror (which involves a lamp cord dangling from the operator). It is generally agreed that a properly illuminated head mirror is not only more brilliant but yields more "critical" illumination than the self-contained units, and it is regrettable that many physicians fall away from its use for thorough examinations.

In working with bed patients it is usually inconvenient to prop a light at an optimal point (e. g., six inches behind and beside the patient's head). A light fastened by universal joints to a rubber shod spring clamp has been suggested by Peluse for those cases in which the furniture provides a suitable point for its support.[1]

From the Department of Surgery and the Department of Nursing, College of Physicians and Surgeons, Columbia University. Submitted February 20, 1946.

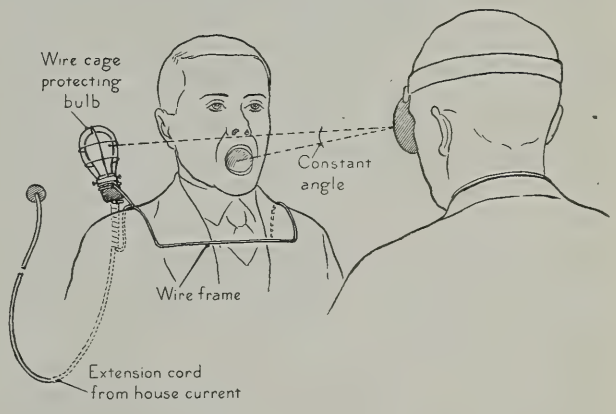
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An even more general difficulty is that, as the patient squirms about, the angle between the light source and the target changes constantly. With experience, adjustment for this becomes largely automatic, but it remains a distraction and is an added physical strain when numerous examinations are made.

All of these difficulties have been met by taping the light to a stiff wire frame which slips over the patient's shoulders. (See sketch.) The



light is thus at once placed and then held at an optimum points for examination of ear, nose, or throat. By keeping such a frame and adequate extension cord together with the head mirror and other components of the examination basket, one has the luxury of proper light with a minimum of preliminary lighting maneuvers. The most important advantage seems to be the fact that once the head mirror is adjusted upon the desired target, it remains focused as the mirror follows the patient, since light and patient move in unison.

BIBLIOGRAPHY

1. Peluse, S.: A New Portable and Utility Light for the Otolaryngologist. Arch. Otolaryngol., 24:624, 1936.

Glycerite of Hydrogen Peroxide: A Correlative Review of Laboratory and Clinical Data

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WORK in progress on the individual aspects of a problem in research frequently results in a group of scientific papers scattered through the journals devoted to special fields of medicine. These are not always available to all physicians, and it would seem desirable that occasional reports be written to correlate, however briefly, representative studies into a single review. The present paper is concerned with a new antiseptic solution for topical application, the following data having been taken from papers recently published, or in process of publication. Only when necessary, for significant reasons, has material been taken from, as yet, unpublished work.

GENERAL DISCUSSION

The solution is a glycerite of hydrogen peroxide. Hydrogen peroxide, discovered in 1818, by Thénard has always been available in aqueous solutions. Its positive virtues are its detergent, deodorant, and hemostatic properties. It is known to be non-toxic, non-allergenic, and in solutions of bactericidal strength, non-irritating. Less often realized are the facts that it is a naturally occurring substance as due to the action of ultra-violet radiation on water and air[6] and also a normal metabolite of aerobic bacteria.[10] Anaerobic organisms which are rich in peroxidase, (the means by which they survive anaerobically) are therefore susceptible to peroxide present in excess. It is also true that hydrogen peroxide possesses a broad spectrum of bactericidal power being relatively nonselective in the bacteria it affects, irrespective of their Gram characteristics.

The present low opinion of aqueous peroxide solutions as antiseptic rest upon the following criteria. Until recent years, the aqueous solutions, commercially available, were not uniformly stable. In the presence of blood, the aqueous solutions decomposed with such rapidity, that any bacteria present could not possibly be affected. On the other hand, laboratory tests in the absence of blood, show such slow killing power that the aqueous solutions were denigrated with a low Phenol Co-efficient.

It is, of course, obvious that a non-phenolic antiseptic solution cannot be tested by the Phenol Co-efficient Method and that secondly, both dilution and time factors are respectively of little importance in a solution used for topical application in chronic infections. This analysis of the Phenol Co-efficient holds equally true for topical applications for preoperative sterilization of the skin, since tinctures so applied grow more and more concentrated as the alcohol-acetone vehicle evaporates. The superficial observer may frequently be beguiled by high dilution figures (say 1:2000) when the initial dilution applied is 1:1000 a dilution factor of only 2:1, the concentrated solution never being used.

It is obvious then that the basic properties of hydrogen peroxide point to theoretical potentialities of an ideal antiseptic if first, its solutions can be stabilized and second, its rate of decomposition can be controlled.

It occurred to Brown, Abramson, and Gorin[2] that a solution of a water-free peroxide in a viscoidal water-free solvent would add to the virtues of peroxide antisepsis. By the application of a physical phenomenon of elementary simplicity, it was discovered that the addition product, urea-hydrogen peroxide, was soluble in substantially anhydrous glycerol. Glycerol has been added to aqueous solutions of hydrogen peroxide in attempts to achieve greater ability, and also, urea peroxide had been added to higher glycerols as carbowaxes with reports that the solutions were not stable. It was subsequently discovered by one of us (E.A.B.) first, that metallic impurities present as trace elements in

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TABLE I

The Measurement of Antiseptic Potency By a Modified Agar Cup Plate Method

Antiseptic	Iodine	Hydrogen Peroxide	Metaphen	Mercresin	Mercurochrome	Zephiran	Phemerol
Vehicle	Tincture	Glycerol	Tincture	Tincture	Aqueous	Tincture	Tincture
Strength	7%	1.5%	0.5%	Standard	2%	0.1%	0.1%
Organism—							
1. Staphylococcus aureus (FDA)	19 mm.	18 mm	(16 mm.)	(19 mm.)	(9 mm.)	11 mm.	9 mm.
2. Streptococcus alpha hem.	28 mm.	20 mm.	11 mm.	(15 mm.)	6 mm.	8 mm.	10 mm.
3. Streptococcus beta hem.	13 mm.	16 mm.	13 mm.	(15 mm.)	(6 mm.)	2 mm	(3 mm)
4. Enterococcus	18 mm.	15 mm.	22 mm	11 mm.	(3 mm.)	6 mm.	(3 mm)
5. Micrococcus epidermidis	22 mm.	11 mm.	9 mm.	12 mm.	6 mm.	(8 mm.)	8 mm.
6. Diphtheroid	22 mm.	(18 mm.)	11 mm.	(16 mm.)	6 mm.	(16 mm.)	5 mm.
7. Proteus mirabilis	13 mm.	16 mm.	(11 mm.)	(9 mm.)	(5 mm.)	(1 mm.)	(1 mm.)
8. Pseudomonas pyocyaneus	21 mm.	15 mm.	(12 mm.)	(12 mm.)	(6 mm.)	4 mm.	(5 mm.)
9. Eberthella typhosa	24 mm.	14 mm.	25 mm	———	5 mm.	(2 mm.)	(2 mm.)
10 Aerobacter aerogenes	23 mm.	12 mm.	9 mm.	11 mm.	5 mm.	6 mm.	(2 mm.)
11. Escherichia coli	9 mm.	10 mm.	(13 mm.)	9 mm.	(6 mm.)	(1 mm.)	(1 mm.)

The measurements are given in mm. from the edge of the cup to the edge of the zone. The numbers in parenthesis refer to the zones which gave positive subcultures and infer that the antiseptic solution was bacteriostatic, at the point of subculture.

the glycerol inactivated the peroxide and second, that oxine (8-hydroxyquinoline) both inactivated the metals and gave added antibacterial potency to the solution although present in high dilution.

The solution consists, therefore, of 1.5 per cent hydrogen peroxide (derived from urea peroxide 4 per cent) in solution in glycerol containing (0.1 per cent) oxine.

The glycerol is hygroscopic and draws plasma to the surface washing the tissues. The oxygen liberated by the decomposition of hydrogen peroxide by tissue peroxidase, cannot break free of the glycerol but leaving the tissue surface continuously renews the interface between the antiseptic solution and the infected area. The remaining urea, a non-toxic physiological substance, is a bacteriostatic agent[15] and dissolves necrotic tissues hastening wound healing.[13] The oxine is also bacteriostatic in high dilution[11] inactivating metallic elements necessary for the normal metabolism of micro-organisms.[16] The antibacterial potency of the solution is slower than that of many antiseptic substances, but more than compensated for by the fact that glycerol solutions will not dry and can, therefore, act for longer periods of time, a virtue as important in the sterilization of a fresh wound as it is in the treatment of chronic infections, which require repeated applications at frequent intervals for long periods of time.

The laboratory data demonstrate[4] that in comparison with the tinctures of iodine (7 per cent), mercresin (standard strength), metaphen (0.5 per cent), zephiran (0.1 per cent), and phemerol (0.1 per cent), as well as aqueous mercurochrome (2 per cent) as measured by the agar cup plate method, using the Gram positive organisms, Staphylococcus aureus, Streptococcus (alpha and beta haemolytic), Enterococcus, Micrococcus epidermidis, diphtheroids, and Gram negative organisms; Proteus mirabilis, Pseudomonas Pyocyaneus, Escherichia coli, Aerobacter aerogenes, and Eberthella typhosa, the solution without oxine approaches tincture of iodine in its antibacterial potency.

It is bactericidal (rather than bacteriostatic) for all of the bacteria, except diphtheroids. Mercresin is bacteriostatic (rather than bactericidal) for six organisms, metaphen for four, mercurochrome for six, zephiran for five, and phemerol for seven. The comparative zones are shown in the accompanying table adapted from the original paper. It should be noted that the hydrogen peroxide content used is 1.5 per cent as derived from the urea peroxide 4 per cent and that each of the other solutions is used in its recommended dilution, in which the alcohol and acetone antibacterial effect is a significant factor.

Since peroxides, both as hydrogen peroxide[7] and zinc peroxide,[9] have been used successfully for oral infections, a laboratory study of the

TABLE II

The total number of bacteria removed from mouth as determined by plating in tryptone glucose agar (average of 6 different tests)

Subject	Initial Count (Normal)	Count After Use of Glycerite of Hydrogen Peroxide (0.75%)				Percentage Decrease After 2 Hours
		10 Minutes	30 Minutes	1 Hour	2 Hours	
1	13,830,000	2,665,000	2,375,000	1,305,000	1,100,000	93%
2	20,950,000	3,090,000	1,920,000	6,200,000	7,100,000	66%
3	5,130,000	1,230,000	1,470,000	2,470,000	3,820,000	26%
4	16,625,000	7,340,000	1,180,000	4,725,000	6,305,000	69%
5	12,762,000	2,571,000	3,825,000	6,400,000	2,390,000	81%
6	9,250,000	6,265,000	5,935,000	6,708,500	2,655,000	71%

effects of glycerite of peroxide on fusiform bacteria was done.

With a technique similar to that used in the work previously mentioned[14] using the fusiform organisms of Vincent's infection, it was demonstrated that successive dilutions from 4 per cent to 0.125 per cent of urea peroxide in glycerol gave zones of bactericidal power ranging from 18 mm. to 5 mm., while pepsodent and listerine undiluted and phenol (1 per cent) gave no zones whatsoever.

In another study combining **in vivo** and **in vitro** techniques[14] the potency of the solution for oral antisepsis was studied. The teeth were brushed with a sterile brush dipped in 4 ml. of urea peroxide (4 per cent) in glycerol as diluted with an equal amount of water. Brushing for 2 minutes was followed by a mouth rinse of 1 minute with 10 ml. of the same solution. Samples of saliva were taken after 10, 30, 60, and 120 minutes after repetition of the same technique using distilled water. Replicate experiments were done on alternate days with the same technique using distilled water instead of the glycerite of peroxide solution. The reduction if viable bacteria varied from 26 per cent to 93 per cent as shown in the second table.

Concomitant tissue tolerance studies were done.[1] Patch tests for 48 hours with urea peroxide 4 per cent in glycerol, oxine (0.1 per cent) in glycerol, and urea peroxide (4 per cent) and oxine (0.1 per cent) in glycerol on 100 normal individuals demonstrated no evidence of irritation. These results would suggest that there is a likelihood at the 95 per cent level that the rate of positive reactions in the general population would not exceed 2.9 per cent. The reference tables indicate[8] that no reaction on 600 individuals gives us a 95 per cent likelihood in fewer than 0.05 per cent of the general population would react. In order to add to the certainty of this possibility, patients who had continued applications of solution were studied. Although some had had continuous wet dressings applied to extensive areas of damaged skin for as long as two months with no signs of irritation, only the data of those patients whose conditions had been adequately controlled were admitted for analysis.

In four separate series of patients, 96 in all, with acute, subacute, and chronic middle ear infections, the solution was applied at 3 to 6 hour intervals from arising to retiring, the treatment periods varying from 4 to 75 days, with no reports of irritation.

In a series of 16 patients with empyemata the material (3 cc.) was injected once or twice daily for three months, and in another series of 8 patients, twice daily for 6 to 14 months with no signs of irritation. On the other hand, 5 patients in a group of 90 with infections of the skin reported exacerbation of their conditions.

In all, 569 patients showed no signs which could be interpreted as the results of irritation, allergenic responses, or toxicity.

The clinical results are those which are of chief interest to the physician.

Thenardol was first used on a series of patients with chronic purulent otitis media following the suggestion of Dr. W. E. Owen[5] that the solution might be useful in the treatment of this recalcitrant type of infection. In a series of 37 patients, varying from 3 to 65 years of age and presenting infections present from 4 to 40 years, laboratory studies showed the following bacteria, among others, to be present alone or in mixed culture; Staphylococci (albus and aureus), Streptococci (haemolytic and non-haemolytic), E. coli, B. Proteus, and diphtheroids.

The treatment period varied from 4 to 38 days, the solution being applied at intervals of 4 hours during the day. All the patients had been treated in the usual way, but ineffectively, with one or more of the following medications, boric acid, boric acid and alcohol, boric acid-alcohol-and hydrogen peroxide, sodium sulfathiazol solution (5 per cent), sulfathiazol or sulfanilimide powder, Sulzberger's powder, tyrothricin, or penicillin.

In this series, 4 patients failed to return, 3 showed no improvement, 2 required penicillin in addition to glycerite of peroxide. Of the remaining patients, 17 cleared completely in 14 days and 12 by the end of the treatment period.

In a corroborative clinical study[3] with 29 patients whose conditions included either acute serous, suppurative, eczematous, furunculous, or

subacute or chronic suppurative otitis media, treatment was given as mentioned above. The same type of bacteria were present. The treatment period varied from 8 to 44 days and demonstrated 20 of 25 patients presenting complete remission. Four patients did not return for follow-up studies.

In 9 patients with empyema in process of study[12] 8 presented empyemata complicated by pleuro-cutaneous fistulae, and the ninth a secondarily infected tuberculous cavity with surgical cavernostomy. In 4 patients there was evidence of broncho-pleural fistulae. In 7 patients there was concomitant tuberculous infection as confirmed by guinea pig innoculation. The secondary invading bacteria was Staphylococcus aureus, beta haemolytic Streptococci, Proteus vulgaris, Pseudomonas pyocyaneus, and diphtheroids.

The treatment consisted of the injection of 3 cc. of the solution twice daily through the cutaneous opening which was immediately closed with a firm sterile plug. In 7 of the 8 patients, in which it was present, the Staphylococcus aureus disappeared in 4 to 14 weeks. The Streptococcus present in 2 patients disappeared in 4 weeks. Proteus vulgaris found on one occasion in the patient whom the Staphylococcus infection was persistent.

In this series, one patient died of acute myocardial failure, and another who has a concomitant diabetes has a hopeless prognosis. Two of the patients are well and working and the remainder present sterile cavities closing or on the process of closure by thoracoplasy. The presence of tuberculous infection did not hinder the effect of thenardol upon the secondary invading organisms.

It would appear from these preliminary laboratory and clinical reports, that glycerite of hydrogen peroxide is an effective bacteriostatic and bactericidal solution for the treatment of certain acute and chronic mixed infections of the skin and mucous membranes in patients treated unsuccessfully with one or more of the usual antiseptic measures.

Although it has been used for a variety of infected conditions, the true evaluation of thenardol must depend upon more studies over longer periods of time. It would seem to possess properties that would make it a useful agent in treatment by topical application of infections of the skin and mucous membranes.

BIBLIOGRAPHY

1. Brown, E. A.: Studies on Tissue Tolerance to a New Glycerol Peroxide Antiseptic Solution. Ann. Allergy, 4:33, 1946.

2. Brown, E. A.; Abramson, H. A.; Gorin, M.; Kauffmann, H. O.: and Shanley, E. C.: The Stability of Urea Peroxide in Glycerol. (Unpublished data.)

3. Brown, E. A., and Kelemen, George: The Use of Glycerite of Hydrogen Peroxide in Inflammatory Aural Conditions. Laryngoscope. (In Press.)

4. Brown, E. A.; Krabel, Wilfred; and Skiffington, Rita: A New Antiseptic Solution for Topical Application. New Eng. Med. Jr., 234:468, 1946.

5. Brown, E. A., and Owen, W. E.: The Treatment of Chronic Purulent Otitis Media with Glycerite of Hydrogen Peroxide. Arch. Otolaryngology. (In Press.)

6. Curran, Harold R.: The Ultra-Violet Radiation of Bacterial Spores. Jr. Bact., 31:3, 1936.

7. Farrell, G. W., and McNichols, W. A.: Efficacy of Various Medicaments in the Treatment of Vincent's Stomatitis. J.A.M.A., 108:630, 1937.

8. Henderson, C. R., and Riby, E. G.: Certain Statistical Considerations in Patch Testing. J. Invest. Derm., 6:277, 1945.

9. Mallet, S. P., and Guralnick, W. C.: Zinc Peroxide in the Treatment of Mouth Infections. J.A.D.A., 29:304, 1942.

10. McLeod, J. W., and Gordon, J.: The Production of Hydrogen Peroxide by Bacteria. J. Biochem., 16:499, 1922.

11. Morel, A.: Sur le pouvoir infertilizant du sulfate neutre de 8-hydroxyquinoline vis a vis des cultures de quelques microbes pathogénes. Compt. rend. Soc. de Biol., 118:257, 1935.

12. O'Brien, W. F.; Brown, E. A.; and Pearse, H.: The Irrigation Treatment of Chronic Empyema with Thenardol (A Stabilized Glycerite of Hydrogen Peroxide). (Unpublished Data.)

13. Robinson, W.: The Use of Urea to Stimulate Healing in Chronic Purulent Wounds. Am. Jr. Surg., 23:192, 1936.

14. Slanetz, L. W., and Brown, E. A.: The Diminution in the Number of Oral Organisms Following the Use of Carbamide Peroxide in Glycerol. Abstract. Jr. Bact., 51:126, 1946; The Effects of Glycerite of Hydrogen Peroxide on Fusiform Bacteria. (Unpublished Data.)

15. Weinstein, L., and McDonald, Alice: The Effect of Urea, Urethane and Other Carbamates on Bacterial Growth. Science, 101:44, 1945.

16. Zentmyer, G. A.: The Inhibition of Metal Catalysis as a Fungistatic Mechanism. Science, 100:24, 1944.

Skin Diseases and Vitamin Deficiencies

Hypovitaminosis and avitaminosis have become well recognized causes of certain skin diseases. It is less known, however, that deficiency symptoms may be induced even when the diet is entirely adequate. Kruse and Jolliffe have pointed out that in addition to a primary malnutrition arising from an inadequate intake of food there exists a rather widespread secondary or conditioned malnutrition. Since the latter seems to play an important role in the pathogenesis of many dermatoses and therefore requires close attention in its management, a short discussion is indicated.

The chief factors conditioning a hypovitaminosis are: (1) interference with food intake due to anorexia, nausea, vomiting, gastro-intestinal disease, food allergy, mental disorders, or dental causes; (2) interference with absorption due to achlorhydria, diarrhea, hepatic or gall-bladder disease; (3) interference with utilization due to diabetes mellitus, liver disease, or chronic alcoholism; (4) increased requirement due to unusual physical activity, fever, hyperthyroidism, pregnancy, or lactation; (5) increased excretion due to gastro-intestinal fistula, excessive perspiration, polyuria, or lactation; (6) therapeutic interference due to therapeutic diets, antacids, mineral oil, diuretics, infusions, or fever therapy.—Erich Urbach, M.D., Philadelphia, Pa.; Pa. Med. Jr., Vol. 49, No. 8, May, 1946.

Tantalum Cranioplasty

OSCAR A. TURNER, M. D.

BASED upon a substantial foundation of experimental and clinical work,[1, 2, 3] it has become evident that sheet tantalum exhibits almost all the major prerequisites of an ideal alloplastic material for the repair of skull defects. It has been used in well over 1,000 cases during the recent war, and work has indicated a definite use for it in civilian practice. The present paper is a discussion of the method of use and the type of fixation of the plate as determined by careful study of a series of 50 tantalum cranioplasties performed by the writer.

Tantalum has been used for the repair of skull defects of surgical as well as of traumatic origin, and has been employed to replace bone removed surgically because of tumor infiltration or infectious process.[4] It serves as excellent material for the cosmetic repair of surgical defects secondary to radical operations upon the frontal sinuses.[5] The properties of the material have been reviewed elsewhere[6] and little need be said other than to emphasize that tantalum itself causes no severe reaction in the presence of infection, nor, as a foreign body, does it prevent healing in the presence of infection, provided adequate drainage of the infected area is established and maintained before the formation of multiloculated pockets and walled-off areas under the plate.

The need for careful contouring of the plate and adequate fixation is illustrated by the fact that over 50 per cent of the cranioplasties performed by the writer involved the frontal region where no concealing growth of hair is present.

PROCEDURE

Except in complicated plates with marked curves in two or more planes, such as are used to reconstruct the supraorbital ridges and orbital margin,[7] very satisfactory results can be obtained by fashioning the plate at the operating table. No special instruments are needed other than a hollow block of wood, a ball-peen hammer, a curved dental pliers, and a heavy scissors. Special instruments have been devised for shelving the bone margin and driving in the tantalum wedges. Although these shorten the operating time, they are not absolutely necessary.

The defect is exposed subperiosteally, using a concealed incision where possible. When the defect is of traumatic origin, it may be necessary to obtain exposure through the old scar. The soft tissues are dissected from the underlying dura, but no attempt is made to free the dura from the under-margin of the bone edge. The pattern of the defect is then transferred to a piece of sterile X-ray film or cottonoid, allowing an overlap of about 3 to 4 millimeters. If the bone edge has become thinned through absorption, a greater overlap is allowed to prevent the area of repair from appearing depressed. Using the heavy scissors, a tantalum plate is cut to correspond with the pattern of the defect. Several holes are made in the plate, these serving to prevent collections of fluid between the plate and the dura and, in the later stages of healing, as additional fixation through growth of connective tissue into the openings. The tantalum plate is then placed in the hollow block and fashioned with the hammer until the correct contour is obtained. Final adjustments are made with the curved dental pliers.

It is necessary to over-correct slightly the degree of curvature to allow for counter-sinking the plate and for thinness of the overlying scalp. The latter may be present when the defect is of traumatic origin. The plate is placed over the defect and its outline scratched upon the skull. A shelf of bone about 1 mm. in depth is then made about the edge of the defect with a chisel, deep enough to allow the edges of the plate to lie evenly with the skull surface. The plate is then fixed in position with several small tantalum wedges driven into the diploic space. For the average plate, 3 or 4 wedges are sufficient. The soft tissues are approximated in layers with interrupted silk sutures without a drain.

During the first 24 hours, it may be necessary to aspirate any fluid collection from beneath the plate, but it is infrequently necessary to do this more than twice.

The necessity of anchoring the plate securely to the bone must be emphasized. Not only does this insure the best cosmetic result, but it is felt that the repeated accumulation of fluid between the plate and scalp is not infrequently caused by irritation from a plate which has been insecurely sutured to the pericranium. Small, well-placed wedges driven into the diploic space not only

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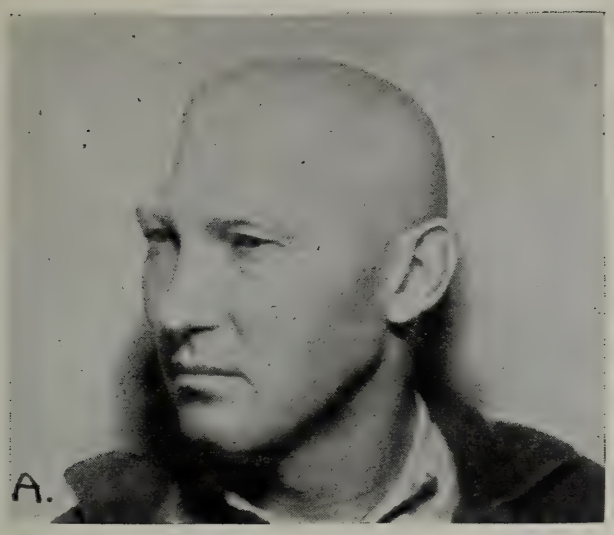


Fig. 1A. Preoperative photograph taken at an angle to show severity of the bone defect.

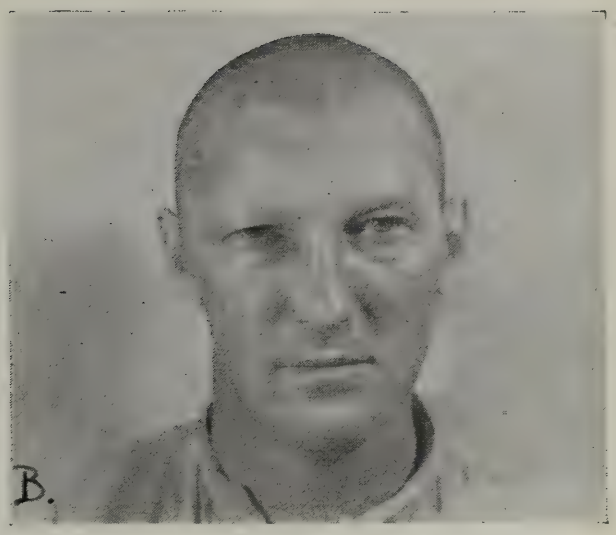


Fig. 1B. Postoperative photograph showing the restoration of the frontal contour.

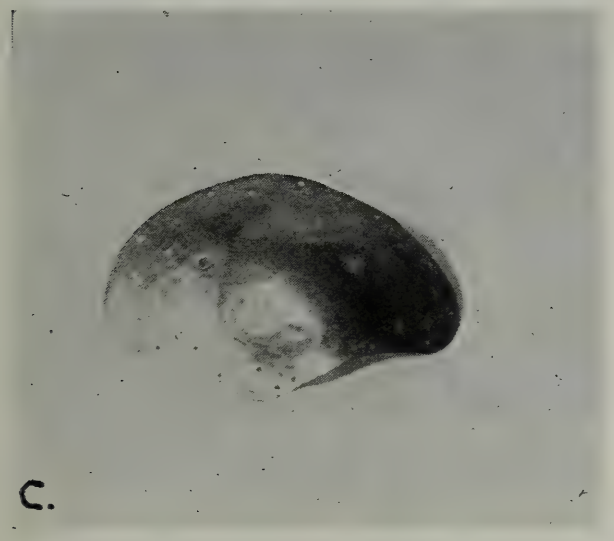


Fig. 1C. Tantalum plate formed prior to operation.

assure immobility, but secure a fixed position for the plate. The latter is particularly important in the frontal region where often only the superior margin of the plate can be fastened.

When the defect is very large or when the tantalum plate has curves in several planes, it may be necessary to form the plate prior to operation. In these instances, an impression is made after the defect has been filled with dental wax and the plate is formed by swedging between positive and negative metallic casts. This is usually necessary in extensive frontal defects which include the supraorbital ridges and in which it is necessary to form a deep shelving border on the plate to fit the orbital roof.[7] The following two cases are illustrative of the results which may be obtained by the use of tantalum in extensive defects of the frontal region.

Case 1. Extensive right frontotemporal defect from gunshot wound. Repair with tantalum plate. This patient sustained a perforating gunshot wound on February 9, 1945. The wound of entrance was just to the right of the midline in the frontal region and the wound of exit in the right anterior temporal region. The right frontal sinus was shattered and there was damage to the right frontal lobe with indriven bone fragments. Despite the fact that at the time of primary operation the membrane lining of the sinus was removed and all bone fragments cleaned from the brain, infection developed which subsequently required further removal of bone from the calvarium. At this time a small brain abcess was drained in the right frontal pole.

At the time of cranioplasty, there was no evidence of infection and no abnormal neurological signs. The large defect measured 7 by 9 cm. and involved the right frontal bone and anterior portion of the right temporal region (Fig. 1A). The medial two-thirds of the supraorbital ridge was absent except for a thin ledge of bone, but the orbital roof was intact. X-ray examination showed that the defect included both walls of the right frontal sinus except for a small area intact laterally. The area of bone loss was sunken and pulsated freely. The overlying scalp was thinned and scarred at the site of the previous drainage.

A large plate was preformed with sufficient overlap to cover the thinned edge of bone at the margins of the defect (Fig 1C). The patient had unusually large frontal sinuses, and some difficulty was encountered in obtaining sufficient prominence to make both sides correspond. The entire bone edge was shelved and the plate fastened with several tantalum wedges driven into the diploic space. The degree of restoration obtained justified the additional care taken to obtain the contour necessary (Fig. 1B).

As the overlying scalp heals, it becomes closely applied to the tantalum plate. For this reason, it is important that no sharp angles, free edges, or irregular open gaps be present over the surface or at the edges of the plate. At the termination of the operation, there should be a smooth surface continuous with that of the skull. This is particularly important in the frontal region where any postoperative asymmetry or irregularity becomes more evident as the scalp edema subsides and healing takes place.

Case 2. Acute osteomyelitis of the frontal bone secondary to acute sinusitis. Extension of infec-



Fig. 2A. Preoperative photograph showing the severity of the defect.

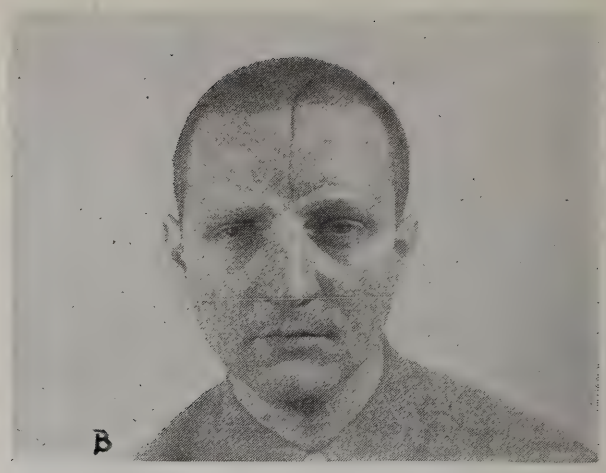


Fig. 2B. Postoperative result.

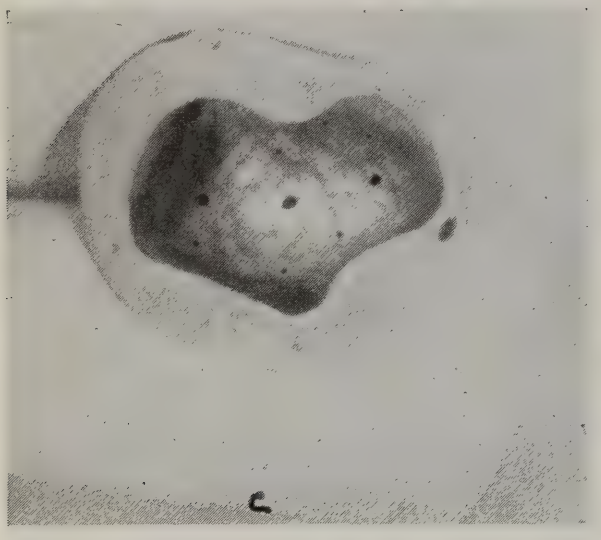


Fig. 2C. Tantalum plate made oversize to allow for corrections at the operating table.

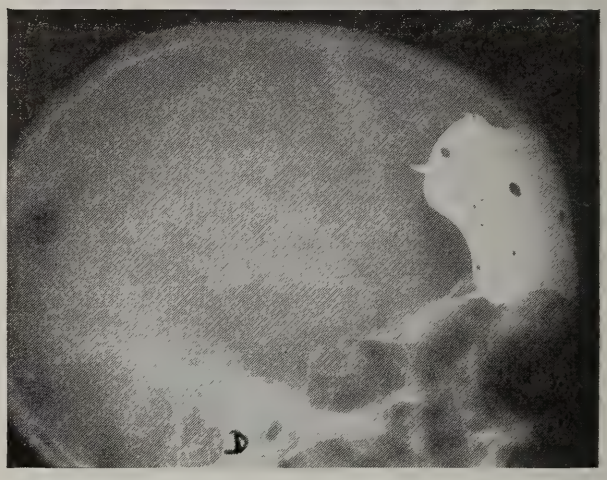


Fig. 2D. Postoperative X-ray. Note the small wedges used to fix the plate in position.

tion to form epidural and subdural abcess. Recovery following open drainage and penicillin therapy. Extensive bifrontal defect repaired by tantalum cranioplasty. This patient developed severe frontal sinusitis which did not respond to the usual measures. One week after the onset of the illness, turbinectomy and irrigation of the left frontal sinus was done. This was followed by drainage of purulent material from which staphylococcus aureus grew on culture. Despite penicillin therapy, X-rays taken about 2 weeks after operation disclosed a suggestion of osteomyelitis of the frontal bone. At this time a bilateral sinusotomy was done and when the necrotic bone was removed, an epidural abcess was uncovered.

One week later the patient developed Jacksonian convulsions which were followed by a right hemiparesis and stupor. He was transferred to another hospital where in addition to the above, examination disclosed blurred optic discs, a positive right Babinski sign, slight stiffness of the neck and a bilaterally positive Kernig sign. Lumbar puncture yielded cloudy fluid under increased pressure.

At operation, most of the frontal bone was found to be involved in the infectious process. A large amount of purulent material was present in the subdural space over the convexity of the brain as well as in the epidural space. Drainage was established by widely opening the dura and only approximating the soft tissue loosely with a few silk sutures. Penicillin was instilled locally and the epidural space was loosely packed with penicillin-soaked gauze. The patient made a remarkable recovery and secondary closure of the wound was carried out.

At the time of admission for cranioplasty, no neurological abnormality was present, other than a mild hyper-reflexia on the right. There was a large frontal defect which measured 9.5 by 6 cm. and involved most of the left frontal region, but extended to the left of the midline (Fig. 2A). The supraorbital ridge was intact but there was loss of bone in the midline at the gabella and near the upper nasal bridge. There was a marked operative scar which passed through both supraorbital regions and which extended vertically up the midline and to the left.

A large bifrontal plate was fashioned which was considerably larger than the defect in order that the final correction could be made at the operating table (Fig. 2C). Because of the number of previous operations the blood supply to the lower angle of the wound was not at its maximum and it was decided that no attempt would be made to excise the soft tissue scar at the time of cranioplasty. The defect was accordingly exposed through the old incision and the scalp dissected from the underlying dura. The bone edge was shelved and the tantalum plate cor-

rected to cover the entire defect (Fig. 2D). A small midline extension was used to repair the defect near the upper nasal bridge in the region of the gabella. The illustration shows the results obtained prior to excision and plastic closure of the midline scar (Fig. 2B).

In this instance it was necessary to approach the defect through the scar of several previous operations. It is preferable to use a coronal incision concealed behind the hairline, reflecting the scalp forward. When a large amount of bone is lacking, the dead space may be reduced and oozing from the dural surface discouraged by the use of several tantalum or silk sutures passing from the dura to the holes in the plate.

While most of this discussion has centered about the cosmetic results which may be obtained, the restoration of the normal, rigid contour of the calvarium has a much more important significance. It must be emphasized that tantalum cranioplasty need not be considered as a separate procedure, but merely as a final stage in any operation in which a cranial defect results. It should be used in the primary treatment of any compound fracture of the skull where there is loss of bone substance. Not only is the rigid box-like structure of the skull restored, but the procedure prevents the formation of pulsion-traction effects upon the brain due to adhesions between brain, dura, and scalp. The writer has seen instances in which considerable improvement followed cranioplasty where a large area of sunken scalp and dura exerted its traction effect upon the brain.

SUMMARY

Tantalum cranioplasty can be performed without undue difficulty or loss of time, and in most instances the plate can be fashioned at the operating table. Aside from the cosmetic results which can be obtained, the physiological effects of removing or preventing scalp-dura-brain traction and the restoration of the rigid character of the skull indicates that cranioplasty should be included as part of any primary operation where any significant amount of skull is removed.

The plate should be carefully fashioned and fastened to the skull with tantalum wedges after the bone edge has been shelved to allow the plate to fit evenly with the skull surface.

BIBLIOGRAPHY

1. Carney, H. M.: An experimental study with tantalum. Proc. Soc. Exp. Biol., 51: 147-148, 1942.
2. Pudenz, R. H.: The repair of cranial defects with tantalum. J.A.M.A., 121: 478-481, 1943.
3. Robertson, R. C. L.: Repair of cranial defects with tantalum. J. Neurosurg., 1: 227-236, July, 1944.
4. Gardner, W. J.: Closure of defects of the skull with tantalum. Surg., Gynec. & Obstr., 80: 303-312, March, 1945.
5. Canfield, N.: Tantalum implants for skull defects, Proc. Roy. Soc. Med. (London), 38: 293-298, April, 1945.
6. Woodhall, B., and Spurling, R. G.: Tantalum cranioplasty for war wounds of the skull. Ann. Surg., 121: 649-671, May, 1945.
7. Turner, O. A.: The repair of skull defects with special reference to the periorbital structures and frontal sinus. Arch. Surg. (In Process of Publication.)

KEEPING UP WITH MEDICINE

IN childhood, paroxysmal tachycardia occurs usually in the presence of an infection.

* * *

INDUCED sensitivity from topical use of the sulfonamides is not rare. Future deaths may be great from septic infections because of the unnecessary local use of the sulfonamides on some trifling skin lesions.

* * *

ALLERGIC reactions to penicillin to date have been for the most part mild.

* * *

A CONVULSION is a symptom and not a disease. Any infection in a child may be ushered in with a convulsion.

* * *

OCCASIONALLY jaundice is a complication of **infectious mononucleosis** which can also produce meningeal irritation, ataxia, poor articulation, nystagmus, and symptoms of involvement of the cerebellum.

* * *

GOOD results achieved in some cases of asthma due to bacterial allergy in children indicate the need of further trial of the oral use of penicillin.

* * *

RECURRENT papulovesicular eruptions appearing after the use of penicillin in patients with antecedent dermatophytoses are not thought to be allergic.

* * *

MOST of us do not pay as much attention as we should in our examination of the mouth.

* * *

IT was the great Thomas Syndenham, "a puritan trooper turned physician", who in 1683 distinguished acute rheumatism from gout.

* * *

WET dressings should not be allowed to dry on the skin.

* * *

VITAMINS necessary to the health of the mouth, teeth, and gums include A, B complex, C, and D.

* * *

THE lack of progress in psychiatry may be attributed to the fact that 95 per cent is practiced as state medicine.

* * *

MALARIA must be looked for in any obscure febrile illness seen in a veteran returned from the tropics or from the Mediterranean.

* * *

CHANGES of residence for the arthritic with hope that a warm, dry climate might be helpful has seemingly aided only a few rather than the majority.—J. F.

Differential Diagnosis between Appendicitis and Adnexal Disease

J. L. BUBIS, M. D.

ALTHOUGH the diagnosis of appendicitis is generally very simple, it can, at times, prove difficult and baffling. The motility and position of the appendix, i. e., whether it is retrocecal, at the brim of, or in, the pelvic cavity, frequently confuses the diagnosis. The question whether the appendiceal involvement is primary or secondary must be considered as well as the mental attitude of the patient. Some women are "appendix conscious", and any digestive disturbance or abdominal pain will send them to the surgeon with a self-made diagnosis and willingness for operation. We also find the opposite type, patients with abdominal pain, nausea and vomiting, constipation or diarrhea, who have taken active cathartics or large enemas in spite of all the recent publicity to the contrary. The pain becomes worse, perforation may result, often followed by generalized peritonitis.

Conditions which must be differentiated from appendicitis are early uterine pregnancy, ectopic pregnancy, renal or ureteral colic, diverticultitis, terminal ileitis, mesenteric adenitis, acute, subacute, or chronic salpingitis, ruptured graafian follicle or corpus luteum cyst, twisted pedunculated fibroid, ovarian cyst, and inflammation of the intestinal epiploica from tortion or strangulation. Attacks of pain from cholelithiasis, peptic ulcer, early lung or pleural inflammation, especially diaphragmatic pleurisy and acute pancreatitis have all been encountered by the author. Tortion of the omentum and decidual reaction in the omentum, as well as umbilical, femoral, inguinal, pudendal, or other hernias must also be considered.

Observation of temperatures, leukocyte counts, and sedimentation rates are valuable, but we may be too easily led astray by over-valuating these and neglecting physical findings. How often have we seen gangrenous or ruptured appendices in cases with practically normal temperatures and white counts, or apparently normal appendices in patients with high fevers and rising leukocyte counts!

Differential diagnosis of ectopic pregnancy, a twisted organ, and acute appendicitis is less important because these call for operative procedures, if an acute salpingitis and ureteral colic must be treated in a different manner. A careful history and complete physical examination will be of great help in making a correct diagnosis. The most important procedure in clinching the diagnosis is, in women, bimanual vagino-abdominal palpation, and in virgins, recto-abdominal palpation. The utmost gentleness must be used. The urinary bladder must be emptied first and a microscopical examination of the urine must be done.

Submitted February 8, 1946.

The Author

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THE TECHNIC

Experience will show the value of the following technic. The position, motility and tenderness of the cervix are determined by bimanual or recto-abdominal palpation. Then the fornices are examined and edema, consistency, and masses are noted. The body of the uterus is gently outlined and its size, position, movement, and the presence or absence of pain or tenderness determined. The uterosacral ligaments are then palpated for size, edema, tenderness, or rigidity. The size, consistency, tenderness, and mobility of the left adnexa are noted.

The right cornua of the uterus is then examined for tenderness and the right adnexa outlined. The fingers in the vagina or rectum and those palpating the abdominal wall are advanced upward and outward toward McBurney's point, palpating carefully the intervening tissue for tenderness and rigidity until the point of maximum tenderness is located. The type of pain or tenderness is noted, and also the direction in which it radiates. By this maneuver we have been able to differentiate between appendicitis and adnexal involvement, and to follow the course of a pelvic appendix and an appendix that is adherent to the uterine cornua or adnexa as illustrated in the following cases.

CASE REPORTS

Case 1. Mrs. L. M. aet. 32 years, married eight years, nullipara. She had not been anx-

ious to have a child because she suffered from right sacroiliac pain, some indigestion, and occasional abdominal cramps. She was a physician's wife and had been thoroughly examined by several internists and orthopedists. X-rays had been taken but no pathologic findings were present. Her past history was negative and there were no gynecological complaints. She was a well built, solid type of woman. There was some tenderness on deep pressure over McBurney's point. Bimanual examination was negative until the fingers on the abdomen approached the above point where the pain became more pronounced. Following this tenderness downward and posteriorly toward the adnexa along the sacroiliac joint, the pain and tenderness gradually decreased. A diagnosis of pelvic appendicitis lying along the sacroiliac joint was made and found at operation. Her pains disappeared and she was delivered of a seven-pound daughter 18 months later.

Case 2. Mrs. C. H. aet. 34 years, nullipara, a widow 10 years. Her past history was negative except that she had been infected with gonorrhea by her husband shortly after marriage. She had been in bed for several weeks at that time on account of pelvic pain, some fever, and a leucorrheal discharge. After the symptoms had subsided, she had resumed her domestic duties with slight discomfort. When seen at the office on June 2, 1909, she complained of slight indigestion, pain in the right lower quadrant of the abdomen, dysmenorrhea, and leucorrhea. Examination showed a small woman weighing 105 lbs. but well developed. A general physical examination was negative. Vaginal examination showed a marital outlet, the cervix pointed backward and movement was slightly restricted by thickened utero-sacral ligaments. The uterus was in good position, slightly enlarged with some restriction of movement. The left adnexa were enlarged and thickened to the size of a hen's egg, slightly tender and fixed. The right adnexa were in about the same condition but by advancing the fingers on the abdomen toward McBurney's point while fixing the adnexa with the fingers in the vagina, I found that the pain and tenderness increased. A diagnosis of chronic inflammatory disease of the adnexa with an appendix adherent to the right tubo-ovarian mass was made and vertified at operation.

Case 3. One of the most common types of chronic appendicitis with exacerbations of pain is the one that has a patent lumen or is kinked by adhesions or by a short appendiceal mesentary. In these cases gas or fecal material enters the lumen of the appendix and causes pain in the right lower quadrant of the abdomen, nausea, and occasionally vomiting. There may be a slight increase in the leucocytotic count, accompanied by a slight rise in temperature. This type is illustrated by the following case.

Mrs. T. L., aet. 22, came to the office on December 1, 1945, complaining of pain in the right lower quadrant of the abdomen for two weeks. Walking aggravated the pain. She had been seen by several physicians, gastro-intestinal X-rays had been taken, and she was told that nothing abnormal was found. The Bubis sign was definitely demonstrated. At the hospital her rectal temperature was 99.4°, WBC was 9,600 per cubic mm. A long appendix lying over the brim of the pelvis and full of fecoliths was found. She came to the office three weeks later stating that she was feeling fine and free from all of her previous symptoms.

CONCLUSION

We have used this diagnosis maneuver many times down the years, and in many cases a diagnosis of appendiceal involvement has been definitely clinched by using this technic. In fact, it has become known as "the Bubis sign" at Mt. Sinai Hospital and is often used as an aid in the differential diagnosis of acute and chronic pelvic conditions.

Eczema and Contact Dermatitis

The external female genitalia are not uncommon sites for the development of an acute, vesicular, weeping, erythematous and extremely pruritic eruption known as eczema or contact dermatitis. The highly eczematogenous substances coming in direct contact with these tissues of sensitive individuals include contraceptive creams and jellies, antiseptic douches, deodorants, perfumes, toilet waters, sanitary napkins and various therapeutic agents. In addition, irritating abnormal vaginal discharges as well as draining fistulae may act as exciting agents.

The acute stage requires soothing treatments with wet dressings of boric acid solution, dilute potassium permanganate or dilute Burow's solution for several days followed by the application of calamine lotion. During the desquamating stage a bland paste such as zinc oxide or Lassar's is to be preferred. When the process has been of long standing the induration, thickening and lichenification of chronic eczema may result. The application of ointments containing tar and/or salicylic acid are employed for chronic eczema along with fractional doses of X-ray. The exciting agent must be sought for and whenever possible removed.

SEBORRHOEIC DERMATITIS

Seborrhoeic dermatitis of the vulva and inguinocrural regions is almost invariably associated with seborrhoeic manifestations at the other sites of predilection such as the scalp, post-auricular areas, axillae and umbilicus.

During the early stages, or in relatively mild cases, the eruption occurs in the form of erythematous, greasy and scaly spots. At this time ointments containing sulphur, salicylic acid, resorcinol and mercury alone or in suitable combinations are used. Untreated, the tendency is for the eruption to become progressively worse finally assuming a moist and crusted character. During this phase wet dressings especially with ⅛ to ¼ per cent silver nitrate are indicated.—Mortimer D. Speiser, M.D., New York City; Conn. State Med. Jr., Vol. X, No. 5, May, 1946.

A Case of Concurrent Encephalitis and Acute Infectious Hepatitis

JOSEPH I. GOODMAN, M.D., and EUGENE V. HANDELMAN, M.D.

CASE HISTORY

THE new concept of infectious hepatitis as a virus disease has it genesis in (1) Epidemiologic observations of this entity in wartime, and especially the recognition of "homologous serum jaundice" in large numbers of individuals following inoculation with yellow fever vaccine; [1, 19] and, (2) studies of the transmissibility of the icterogenic agent in humans and animals.[7,19,24]

The following case report appears to substantiate on clinical grounds this approach to the understanding of the etiology of this disease.

A 20-year old white male soldier arrived in the United Kingdom on 15 November 1944, after a 15-day period aboard ship in transit from the United States. On 19 November, he became ill with chills and fever, a mild frontal headache and vomiting. There was a feeling of nasal congestion and dryness of the throat. On the day of admission to the hospital, 20 November, the essential findings were as follows: Temperature of 102.6 F., congestion of the nasal mucosa and pharynx, and a blood pressure of 122 systolic and 80 diastolic. There was no lymphadenopathy, rash, nucchal rigidity, or abnormal physical finding of the lungs, heart, and abdomen. The white blood cell count was 5,050; the differential count consisted of 59 polymorphonuclear cells, 35 lymphocytes, 2 monocytes, 3 eosinophiles, and 1 basophile in 100 cells counted.

On 21 November, the headache became more intense. He complained bitterly of pain in the lower back and stated he felt "dopey". At this time, nucchal rigidity was present, as well as a positive Brudzinski sign on the right side. A lumbar puncture was done. The fluid was grossly clear and the pressure not increased. There were 353 cells per cm., consisting chiefly of polymorphonuclear cells. The test for globulin was negative and the sugar content was 30 mgs. per 100 cc. No organisms were present in the smear or on culture.

By 22 November, the headache had disappeared, but the bone pains, especially those in the back, were accentuated to such a degree that the slightest movement produced pain. Vomiting prevented his retaining food. A weakness in both upper extremities was detected. There was marked stiffness of the neck and the Brudzinski sign was positive bilaterally. The biceps reflexes were absent; the triceps reflex was elicited weakly on the right and was absent on the left. The Achilles reflexes were hyperactive. The abdominal reflexes persisted and there were no sensory changes. The patient was lucid and cooperative. The temperature was 103 F. and the white blood cell count was 6,950. The differential white cell count included 65 polymorphonuclear cells with 8 stab cells, 29 lymphocytes, 4 monocytes, and 2 eosinophiles in 100 cells counted.

On 23 November, he appeared drowsy and his speech had become hesitant. The weakness of the upper extremities and the rigidity in the neck had increased. There was muscle weakness of the lower extremities with concomitant bilateral absence of the patellar reflex. The Achilles reflexes had become sluggish. A diagnosis of encephalitis was made.

The following 24 hours brought about significant improvement in the headache, backache and weakness, together with a drop in temperature to normal. A lumbar puncture was done and the spinal fluid was sent to a specialized laboratory for virus study. Attempted isolation of the virus by inoculation of the spinal fluid and blood into mice and guinea pigs was unsuccessful. Serodiagnostic studies of the blood were similarly reported negative.

There was complete return of normal muscle power in all the extremities on 26 November. However, the tendon reflexes, with the exception of the Achilles, were still absent. The drowsiness and vomiting persisted until 28 November. On this day, there was noted icterus of the skin and sclera, and the liver was estimated to extend 3 to 4 fingerbreadths below the right costal margin. There was an overlying area of tenderness. The red blood cell count was 4,666,000, the hemoglobin 15 grams, the white blood cell count was 7,900. The differential count consisted of 61 polymorphonuclear cells with 2 stabs, 36 lymphocytes, 2 monocytes, and 1 eosinophile in 100 cells. The urine was dark brown, but clear; the reaction acid, the specific gravity 1.016. There was no albumin or sugar; the test for bile was negative and urobilinogen was positive in a 1:10 dilution. Microscopic examination showed rare white and red blood cells. The icteric index was 33.4. The temperature,

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which had been normal for 96 hours, rose to 100.4 F.

On 30 November, the severity of the liver infection reached its peak. The temperature rose to 101 F. and the icteric index to 71. Other pertinent data included a total protein of 8 grams per cent with albumin 4.8 and globulin 3.2. There was instituted a rigid program of controlled hourly food intake, whereby the patient consumed a minimum of 5,000 calories each 24 hours, consisting predominantly of carbohydrate and protein. There had been a weight loss of 15 lbs. during the first week of this illness.

Within 48 hours of the institution of the above dietary regimen, there was no further vomiting. Associated with the markedly enlarged liver, which at this time (2 December) was discernible four fingerbreadths below the right costal margin and seven fingerbreadths below the xiphoid process, there was a moderate degree of tenderness to palpation. All of the neurologic aspects of this case had resolved and the spinal fluid was normal on 5 December.

After several days, there was significant diminution in the size of the liver and the icteric index which dropped to 38 on 6 December. The temperature remained elevated, 101 F., although the pulse rate was not correspondingly high.

On 7 December at 1430 hours, the patient voided a grossly bloody urine. This was followed at 1800 hours by the onset of pain, at first in the left testis, and subsequently in the left lumbar region. This pain became so severe that morphine was required. On examination there was present a moderate degree of left costovertebral tenderness without spasm. Patient was examined by a genito-urinary consultant, who suggested that the left kidney was the source of the bleeding and that colic resulted from passage of a clot down the left ureter. A calculus did not appear likely and a tumor remained to be excluded.

The laboratory data pertaining to this episode follows: The non-protein nitrogen was 40.2 (mgs.) per cent; the creatinine 1.7 (mgs.) per cent; the clotting time was 2 minutes 30 seconds; the bleeding time 1 minute 30 seconds; and the prothrombin time 78 per cent of normal. The icteric index, serum protein, red blood cell count, and hemoglobin were unchanged. The white blood cell count was 10,600.

The duration of the pain was 36 hours, during which varying-sized blood clots were present in the urine, which had assumed a gross appearance not unlike coca cola. A flat film of the kidney, ureter, and bladder on 8 December revealed no opaque calculi. The urine had a specific gravity of 1.010 with 1 plus albumin and microscopically was loaded with red blood cells.

By 9 December the urine had become normal. This terminated all signs and symptoms referable to the gentio-urinary tract. An intravenous pyelogram on 13 December clearly showed blunting of the calyces and lack of filling of the pelvis which was interpreted by the roentgenologist to be consistent with a blood clot. A retrograde pyelogram on 16 December revealed a filling defect in the pelvis of the left kidney and blunting of the superior calyx. The differential diagnosis lay between a residual blood clot and a renal tumor. Finally, on 2 January 1945, the cystoscopy was repeated and the pyelogram again indicated calyectasis of the left major superior calyx. There was in addition a minimal narrowing of the infundibulum of the superior calyx with a filling defect at this site.

Throughout the period of the renal symptoms and afterwards, the patient made rapid clinical improvement. The liver attained normal dimensions, and the icteric index reverted to normal on 23 December. At the time of his discharge, he had gained 25 pounds and was entirely asymptomatic. However, in view of the persistent roentgen findings in the left kidney, it was deemed advisable to return him to the United States for continued observation.

CONCLUSION

In our opinion, it is fair to assume that the diagnosis of encephalitis has been established satisfactorily in this case. This view is supported by the characteristic acute onset, severe headache, vomiting, drowsiness and the objective findings of absent reflexes associated with weakness of the extremities, neck rigidity, and the spinal fluid findings. Anterior poliomyelitis can be excluded only presumptively after reviewing the course of the illness. The spinal fluid data are not consistent with a bacterial meningitis.

Recent investigative work has enabled us to accept without question the virus nature of some forms of encephalitis. Attempts to isolate or identify such a virus by animal inoculation and serodiagnostic tests were unsuccessful in this case. However, this does not detract from the obvious virus stigmata of his illness. These are: severe pains in the muscles, joints, and bones, marked hyperhidrosis, relative bradycardia and leukopenia, as well as the more specific central nervous system symptomatology consistent with encephalitis.

This case raises the question of whether the hepatitis-encephalitis relationship is more than coincidental. We have no evidence in this instance to substantiate or deny such a relationship. For the present, we can do no more than speculate concerning a common etiology. The presence of a virus which attacks simultaneously two or more organ systems, such as the central nervous system and the liver in this case, is in keeping with the pathogenesis of virus infections. Before accepting such a relationship, the more familiar causes of hepatitis must be negated. In a soldier patient, it is essential to consider the possible role of yellow fever vaccination. This patient had no such inoculation. The toxic effect of drugs, particularly the sulfonamides, is well known. Fortuitously, this patient was given only infrequent doses of acetylsalicylic acid and ephedrine nose drops prior to the onset of the hepatitis. These could hardly cause a toxic reaction in the liver. The survival of the guinea pigs inoculated with this patient's blood, the leukopenia and his recent arrival from the United States appear to exclude Weil's disease.

In view of these observations, we submit this case as being highly suggestive, from a clinical aspect, of the recently proposed relationship of

viruses to hepatitis, now postulated chiefly on epidemiologic and experimental evidence.

BIBLIOGRAPHY

1. Infective Hepatitis in the War. Foreign Letters (London), J.A.M.A., 127:879, March 13, 1943.
2. Catarrhal and Human Serum Jaundice. Editorial; Ibid., 122:746, July 10, 1943.
3. Problem of Infectious Jaundice. Editorial; Ibid., 122:1186, Aug. 21, 1943.
4. Epidemic Hepatitis or Catarrhal Jaundice. Editorial; Ibid., 123:636, Nov. 6, 1943.
5. Dietrich, S.: Der Sogenannte Katarrhalische Ikterus und die Hepatitis Epidemica. Deutsche Med. Wchnschr. 68:5, Jan. 2, 1942
6. Gutzeit, K.: Icterus Infectiosus. Munchen Med. Wchnschr. 89:185, Feb. 27, 1942.
7. Epidemic Jaundice. Editorial, N. Eng. Jr Med., 230:297, 1944.
8. The Outbreak of Jaundice in the Army. J.A.M.A., 120:51, 1942.
9. Edwards, L. R. L.: Outbreak of Epidemic Catarrhal Jaundice. Brit. M. J, 1:474, 1943.
10. Ford, J. C.: Infective Hepatitis: 300 Cases In an Outer London Borough. Lancet., 1:675, 1943.
11. Van Rooyen, C. E. and Gordon, I.: Some Experimental Work on Infective Hepatitis in Middle East Forces. Jr. Roy. Army Med. Corps, 79:213, 1942.
12. War Office: Infective Hepatitis. Army Med. Dept. Bull. No. 15, 1942.
13. Cameron, J. D. S.: Infective Hepatitis. Quart. Jr. Med., 12:139, 1943.
14. Stuhlfauth, K.: Epidemic Jaundice, Group Outbreak Amongst Soldiers and Civil Population in Norway. Bull. War Med. Abs., 3:213, 1942.
15. Simpson, W. M.; Powers, W. L.; and Lehman, R. G.: Acute Infective Jaundice at U.S Naval Base Hospital Number ____. U. S. Nav. Med. Bull., 41:1620, 1943.
16. Medical Officers of British Ministry of Health: Homologous Serum Jaundice. Lancet, 1:38, 1943.
17. Jaundice from Human Serum. Editorial, N. Eng. Jr. Med., 229:91, 1943.
18. Fox, J. P.; Manso, C.; Penna, H A.; and Para, M.: Observations on Occurrence of Icterus in Brazil Following Vaccination Against Yellow Fever. Am. Jr. Hyg., 36:68, 1942.
19. Findlay, G. M., and Martin, N. H.: Jaundice Following Yellow Fever Immunization: Transmission by Intranasal Instillation. Lancet., 1:678, 1943.
20. Andersen, T. T.: Etiology of Hepatitis Epidemica (Epidemic Jaundice). Acta Med. Scandinav., 93:209, 1937.
21. Andersen, T. T., and Tulinius, S.: Etiology of Hepatitis Epidemica (Epidemic Jaundice). Acta Med. Scandinav., 95:497, 1938.
22. Voegt, H.: Etiology of Epidemic Hepatitis. (Abs.) J.A.M.A., 123:1002, 1943.
23. Beckman, H.: Treatment in General Practice, 34th Ed., 1938, p. 423.
24. Anderson, W. A. D.: Synopsis of Pathology, 1942, p. 97.

Penicillin in Acute Cholecystitis

The paucity of reports dealing with the use of penicillin in acute cholecystitis is somewhat surprising in view of the fact that organisms known to be penicillin sensitive (as well as those known to be penicillin insensitive) are among those incriminated as causative agents. From a practical standpoint, it is rarely possible, in spite of Lyon-Meltzer drainage and bacteriologic study of duodenal aspirate, to determine the nature of the offending bacterium involved in a case not submitted to operation. Since it is known that penicillin is recoverable in the bile in concentration sufficient to be effective against penicillin-sensitive organisms, the rationale for the use of penicillin in those cases of acute cholecystitis not subjected to operation, for whatever reason, is apparent.—Randolph Rosenthal, M.D., New York City; N. Y. State Jr. of Med., Vol. 46, No. 7, April, 1946.

Acute Coronary Insufficiency

The prognosis of acute coronary insufficiency without acute occlusion, even when myocardial necrosis results, is usually better than that of acute coronary occlusion with infarction.

The distinction between the two kinds of acute coronary insufficiency is confused by careless use of terms. Acute coronary insufficiency with occlusion, or simply acute coronary occlusion should be the expression only used when a sudden complete obstruction of a vessel is signified. The clinical syndrome and the electrocardiographic findings are clear, and the diagnosis is readily made. The qualifying adjective "acute" should be employed in order that the sudden catastrophic episode will be clearly distinguished from the chronic progressive arteriosclerosis of a coronary artery resulting in partial or practically complete obstruction of the lumen

The qualifying phrases "with or without acute occlusion" are essential. The expression "acute coronary insufficiency" alone is not adequate, since it possesses diverse connotations to different investigators. It is very often employed to include all of the acute coronary diseases, whereas many German authorities and some American physicians, employ the form in the restricted sense of acute coronary insufficiency without occlusion.

Some physicians make use of the expression "myocardial infarction", and do not qualify it in any way. This makes matters worse, for this term is very broad and is misleading. If employed at all, it should be indicated whether or not acute coronary occlusion is present. Furthermore, the acute changes in the myocardium in acute coronary insufficiency without acute occlusion is of the nature of disseminated foci of necrosis, rather than the massive myomalacia which the word "infarction" symbolizes.

It is appreciated that in isolated instances the distinction between the two types of coronary insufficiency may be difficult, but in general, the diagnosis will be made as readily as one makes it in acute appendicitis. In the latter disease, the clinician will occasionally find the diagnosis troublesome. However, with an appreciation of the clinical and electrocardiographic characteristics that have been outlined, one will be able to specify the type of acute coronary insufficiency present.—Arthur M. Master, M.D., New York City; N. Y. Med., Vol. II, No. 9, May 5, 1946.

The Rh Factor

ANSON LEE BROWN, M.D.

DEFINITION

A NEW factor termed the Rh has been discovered in both human and animal blood. This discovery has already proved to be of great importance to medical practice. While working with various animal sera, an agglutinogen was discovered in the erythrocytes of the Rhesus monkey, which also occurs in the red blood cells of 85 per cent of white individuals. This agglutinogen has been called the Rh factor. The nomenclature Rh was taken from the first two letters of the word Rhesus.

HISTORICAL

This discovery was made by Landsteiner and Weiner in 1940. Levine has made important contributions to the Rh factor as well as Boorman, Diamond, and others.

The discoverers injected monkey blood into rabbits and guinea pigs. In so doing, the rabbits and guinea pigs became sensitized to the monkey blood and an immune serum was obtained. This serum then had an agglutinable factor entirely different from the previously discovered types, that is, different from A, B, AB, O, and different from the M and N agglutinogens.

INCIDENCE

It has been found that from 85 to 87 per cent of all individuals show positive. Then 13 to 15 per cent of all persons will show a negative reaction. By positive, one means agglutination takes place between the cell suspension of the patient and the testing serum. On the other hand, a negative test does not show agglutination between a cell suspension of the patient and the testing serum.

In our laboratory we have found that 70 per cent of 800 bloods have shown an Rh positive. Of course, the remainder would be 30 per cent. These figures differ from the above because most of the tests we are asked to do are taken from pregnant women. Very few men are in this group of 800 bloods.

To better understand the incidence of possible trouble in an improper mating, the author has suggested the following supposition:

Out of 1,000 multiparous pregnancies, it would be safe to state that about 150 would be Rh negative. Now, of these 150 women, let us assume that 10 per cent would be married to Rh negative males. This then leaves only 135 out of 1,000 such pregnancies. In per cent this would be 1.35. Going further, it is stated by various men that only 1 in 50 is readily sensitized. So you can see that this percentage of 1.35 would easily be cut in two.

Presented before the Pickaway County Medical Society, Feb. 1, 1946.

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IMPORTANCE

A—Transfusion:

The transfusion of an Rh postive blood into an individual having an Rh negative blood may lead to serious consequences. The two ideal conditions for transfusion would be a negative Rh blood given to an Rh negative recipient. The other way would be to give an Rh positive blood of a donor to an Rh positive patient.

An Rh positive blood should never be given to an Rh negative patient.

I imagine that a slight reaction might be obtained when an Rh negative blood would be given to an Rh positive patient. This, however, is quite rare and not much is known about this combination.

B—In Paternity:

Many times the laboratory is called upon to do paternity tests. At most they have not been too satisfactory. The Rh factor would be of some small help if these conditions would arise:

An Rh negative male mated with an Rh negative female could not give rise to an Rh positive baby. Conversely, it is almost impossible to have an Rh negative baby from two positive parents (Mendelian dominant). This will be shown later on the inheritance of the Rh factor.

C—In Erythroblastosis Fetalis:

This is a diseased condition of the fetus and newborn in which there has been an immunological incompatibility between the fetus and the mother. This occurs in a female with an Rh negative and whose husband is an Rh positive. The Rh positive of the male carries over to the fetus. The fetus then acts like a foreign body. Due possibly to some defect in the placenta, fetal blood enters the circulation of the mother. The mother then creates antibodies which in turn pass back through the placenta

into the fetal circulation. This then causes an extensive destruction of the red cells of the fetus and the condition of erythroblastosis fetalis results. The term itself means "the large increase of erythroblasts" (nucleated red cells).

WHAT, THEN IS ERYTHROBLASTOSIS FETALIS?

This is a very severe blood condition of the fetus and newborn in which there has been an immunological incompatibility between the mother and the fetus. The red cells have been destroyed in enormous amounts. There may be edema of the newborn. Icterus is common in 12 to 48 hours. There is a marked and progressing anemia. There may be a large placenta. Many erythroblasts are found in the circulating blood. The liver and spleen may be enlarged. The amniotic fluid may be tinged with bile. Petechial hemorrhages may appear. The hemoglobin may be as low as 25 while the red count may drop to below 1,000,000. The reticulocytes are increased and the bleeding time is prolonged. The urine of the baby may contain bile and the feces may be lacking in bile.

At this point, it might be well to impress upon you that not all cases of jaundice and severe anemia in the newborn are due to Rh complex. Always think of **syphilis.** And when in doubt do a serological examination.

Synonyms for Erythroblastosis Fetalis:

Congenital Hydrops
Anemia of the Newborn
Icterus Gravis
Icterus Gravis Neonatorum

Child Affected:

The condition usually skips the first child. If the condition is to exist it will attack those after the first born. It must be borne in mind, however, that not all cases of pregnancy in which Rh negative mothers have Rh positives fetuses will result in erythroblastotic babies. The possibility of this relationship of the Rh mother and the fetus approximates 10 per cent, whereas erythroblastosis occurs only once in 400 births. The chief explanation for the relative infrequency of the erythroblastosis lies in the normal impermeability of the placental barrier, and in individual differences of mothers in development of an immune response.

On the other hand, erythroblastosis has been shown to occur in Rh positive mothers. This can not be layed to the Rh factor, but to some other condition especially lues.

INHERITANCE OF THE RH FACTOR

Mating:

Rh positive plus Rh positive—Rh pos. 93 per cent; neg. 7 per cent.

Rh positive plus Rh negative—Rh pos. 72 per cent; neg. 28 per cent.

Rh negative plus Rh negative—Rh pos. none; neg. 100 per cent.

In the author's experience, three cases are noteworthy of mention:

The Brunner Case:

Father—Rh positive; mother—Rh negative.

First Child—positive; second child—died.

Third Child—positive; almost died; hemoglobin-20; many erythroblasts found; given two blood transfusions and iron. After three years the child is not too rugged.

The baby, a boy of two months, was seen by me three years ago. The father and mother were sure that the baby had lost considerable blood at the time of circumcision. When they questioned the attending doctor he assured them that an undue amount of blood was not lost. After checking the baby's blood picture, a pediatrician was immediately consulted. The latter immediately gave the boy two small transfusions of his (the doctor's) blood. With the blood transfusion, iron was also given and the baby improved in a few days and was taken home. After three years, we were able to diagnose erythroblastosis fetalis.

The Barr Case:

Mother—Rh positive; Father—Rh negative.

Doris, 15—Rh positive; Margie, 17—Rh negative.

Don, 9—Rh positive; Elsie, 19—Rh negative; Jean, 22—Rh negative.

The second case of interest is titled "The Barr Case". In this one, it is to be noted that the mother is an Rh positive married to an Rh negative male. It is important to note the icidence of the Rh negative and Rh positive as inherited in the five children.

The White Case:

	Age	Common Type	Aggluti-nogen	Rh Factor
Father—				
Thomas White	42	A	MN	Rh pos.
Mother—				
Mrs. White	40	O	MN	Rh pos.
First Child—				
Eugene	16	O	MN	Rh pos.
Second Child—				
Nancy	14	A	MN	Rh pos.
Third Child—				
Thomas	12	A	MN	Rh pos.
Fourth Child—				
Norma	10	O	M	Rh pos.
Fifth Child—				
James, first twin	6	A	M	Rh pos.
Sixth and Seventh—				
Jean } twins	3½	A	MN	Rh pos.
Jane }		A	MN	Rh pos.
Eighth and Ninth				
Marilyn }				
Carolyn } twins	3 mos.	A	N	Rh pos.
		A	N	Rh pos.

The third case is given because this family is quite unique. Please note the following:

1. The first four children born are singles.
2. The last three pregnancies have been twins.
3. The mother and father are both MN. This then shows the children may be any type,

namely, M, N, or MN. This is exactly correct as shown in the chart.

4. Having both parents with Rh positive, 93 per cent of the children will be Rh positive and only 1 per cent will be Rh negative. In this case 100 per cent of the children were Rh positive.

5. Another important finding was the differences noted in the M and N agglutinogens in the three sets of twins. In the first we find M, in the second both have MN, while in the third set both are N.

6. The common types also run true to form. With parents of A and O, all the children in this family are A and O.

PREPARATION OF THE BLOOD FOR THE TEST

A. Clotted blood is preferred when sent to our laboratory. Here the suspension of the cells will be made by the technician.

B. Into one cc. of saline solution add two drops of the patient's blood (from finger or ear).

C. Citrated blood may also be used and a cell suspension of the blood may then be prepared.

WHO SHOULD BE TESTED FOR THE RH FACTOR?

1. The test should be made upon those individuals who have experienced some ill effects from a blood transfusion.

2. Upon all pregnant women after the first child has been born.

3. For paternity cases.

SUMMARY

The blood of man becomes more mysterious with the passing years. In each of our bloods we have specific isoagglutinins and isoagglutinogens. These complex substances are conveniently placed into four groups, namely, A, O, B, and AB. Such groupings were made by Landsteiner at the beginning of the century. Back in 1927 further work was done on the various groups and we then added three other types which are M, N, and MN. These three are quite important in cases of disputed paternity.

Within the last few years a new name has appeared in the literature, namely the Rh factor. Unfortunately, too many popular magazines have taken up the seriousness of such findings. As one doctor friend of mine recently said, "It is just another new thing for the doctor to worry about".

Briefly, the importance of the test can be said in a few lines. An Rh negative woman married to an Rh positive man might have difficulty with any pregnancy after the first one.

The other important thing to remember about the factor is in connection with blood transfusions. An Rh negative patient should not receive blood from an Rh positive donor.

There may be some little significance attached to it in cases of paternity.

While the Rh factor is a normal blood finding, it becomes important to the doctor when Rh negative individuals become sensitized. Such sensitization may give rise to complications following pregnancies or blood transfusion. It is fortunate that only one in 50 Rh negative persons is readily sensitized and it must be emphasized that Rh is not a formidable danger because of this low incidence (2 per cent).

These combinations cause no worry or trouble in this maze of Rh knowledge:

1. Rh negative female mated to Rh negative male.

2. Rh positive female mated to Rh positive male.

3. Rh positive female mated to Rh negative male.

This combination is the one that might cause trouble:

Rh negative female mated to Rh positive male.

If erythroblastotic babies are born alive they may be saved by two or three transfusions (50-75 cc.) with Rh negative blood.

Malaria

1. When a physician encounters a veteran with chills and fever who has had service in a malarial region, he should consider the possibility of malaria, ambiasis and other tropical diseases.

2. In cases of trauma, surgery or other illness in veterans of World War II when the clinical course is complicated by chills and fever, malaria should always be excluded. From our experience we find this is not infrequent and presents a problem to all section of the country. Many expensive and time-consuming laboratory studies may be avoided in such instances if physicians are malaria-conscious.

3. When the course of malaria is complicated by diarrhea, amebiasis should be excluded since amebic dysentery and malaria are frequently found coexisting in the same patient.

4. Atabrine and quinine do not cure vivax malaria and recurrent attacks are common and requenly bizarre. The interval between recurrent attacks may be only a few days.

5. Blood smears are easily done and should properly precede therapy with atabrine or quinine.

6. The coexistence of malaria with other diseases constitutes a challenge to the diagnostic acumen of the medical profession and presents a very interesting problem.—D. E. Nolan, M.D., H. Warshawsky, M.D., and G. W. Pedigo, M.D., Dayton, Ohio; Minn. Med., Vol. 29, No. 5, May, 1946.

Cystic Fibrosis of the Pancreas in an Adult*

H. K. HELLERSTEIN, M.D.

L. C., a 35 year old Negro male, was admitted to Lakeside Hospital, December 4, 1945, with a chief complaint of chest pain. At 3:00 a. m. on the day of admission, the patient noted sudden onset of pain in the left chest intensified by deep inspiration. He had a cough productive of copious amounts of brownish-red sputum, accompanied by chills and fever. In June, 1943, the patient had been seen in the Out-Patient Department because of profuse night sweats, anorexia and painless jaundice. Chest X-rays were negative. No history of gastrointestinal disease or abnormal stools was obtained.

On admission the patient was in acute respiratory distress, complaining of sharp pain in the left chest. Temperature was 39.6° C., pulse rate 140, respiatory rate 32, and blood pressure 95/58. Sclerae were muddy yellow. The pharynx was markedly hyperemic. There was splinting of the left thoracic cage, with pain on inspiration; respirations were shallow and rapid. In the left axilla extending posteriorly there was dullness to percussion and breath sounds were diminished. No rales were heard. The heart was negative. The urine was normal. The red blood count was 3.25 M.; hemoglobin, 72 per cent; and white blood count, 5,000 with essentially normal differential count. Blood Wassermann was negative. Blood urea nitrogen was 12.8 mg./100 cc., blood chlorides 90.6 mEq., icterus index 13. Gram stain of the sputum and typing revealed Friedlander's bacillus, type A. X-ray of the chest revealed consolidation in the left upper lobe.

Intravenous sulfadiazine, glucose and saline were given. The temperature rose to 40.9° C. and pulse rate to 188. Blood pressure fell to 78/50; the sputum became increasingly abundant, tenacious and rusty. Twelve hours after admission the patient died.

Autopsy (9006) revealed confluent bronchopneumonia with pleurisy involving the upper lobe of the left lung, cystic fibrosis of the pancreas and marked fatty metamorphosis of the liver. There was no bronchiectasis, cystic disease of other organs, or epithelial metaplasia. Friedlander's bacillus was cultured from the lung, heart's blood, spinal fluid, and tracheal secretions. The pancreas weighed 136 grams and measured 20 cm. long, 2-3.5 cm. wide and 1.5 cm. thick. In the tail there were two separate cysts 1 x 2 x 1 cm. and 3 x 2 x 2 cm. which contained dark brown fluid and greenish-brown semisolid material. The wall of the cysts measured 3 mm. in thickness and the lining was yellowish-gray, rough and irregular. Numerous similar smaller cysts, varying from 0.5 to 1.2 cm. in diameter, were located in the head and body of the pancreas.

Microscopically there was diffuse fibrosis of the pancreas with atrophy and destruction of acinic tissue but preservation of islets. Some of the larger cysts were lined in part with duct epithelium, and the smaller ones were plainly dilated ducts. They contained finely and coarsely granular eosinophilic or eosinophilic homogeneous concentrically laminated material.

COMMENT

Although this patient died of Friedlander's pneumonia, the finding of chief interest was the incidental discovery of cystic fibrosis of the pancreas. Following Anderson's study[1] which correlated pancreatic cystic fibrosis with the development of celiac disease in children, this disease has been more frequently recognized than previously.[6,9] However, the number of reported cases of cystic fibrosis of the pancreas in adults is small.[8,12] Gruber[12] in 1929 described 23 cases of congenital cystic pancreas of which 12 occurred in adults whose ages ranged from 23 to 83 years.

No definite cause for pancreatic lesions has been found. The disease may be congenital since it is found in infants who die in the first week of life due to meconium ileus.[11] Wegelin, Yamane and Teuschler[12] regard the cysts as errors in development, i.e., dysontogenetic.

Experimental ligation of the pancreatic duct may reproduce the clinical features of cystic fibrosis of the pancreas.[1] Ten per cent of normal pancreas is required to prevent the appearance of symptoms. Hence, in adults who have had the disease since childhood it is possible that sufficient functioning pancreas remains to prevent the onset of symptoms. The development of clinical vitamin A deficiency[1] is attributed to the absence of lipase production in the pancreas and failure to absorb those fats in which vitamin A is soluble. Experimentally, the relation of pancreatic juice to fatty infiltration and degeneration, and to cirrhosis of the liver has been demonstrated in the depancreatized dog.

The morphological features of this case are typical. In some cases the pancreatic ducts and bronchi show metaplasia. The lungs are in-

*Selected by H. T. Karsner, M.D., from the Clinical-Pathological Conferences at the Institute of Pathology, Western Reserve University and University Hospitals, as the thirty-second of a series of cases to be published under the heading "Case Records Presenting Clinical Problems".

volved in every case in the younger age groups so that cystic fibrosis of the pancreas can be suspected[4,10] by the roentgen appearance of the associated pulmonic lesions. The liver is the seat of fatty metamorphosis in a large percentage of cases and cirrhosis is not infrequently reported.[2] Other lesions include strictures and atresia of the small intestine, biliary passages, or urinary tract. Cystic disease of the pancreas may or may not be associated with single or multiple cysts in the liver, kidney, or brain (Gruber).

Signs and symptoms in infants and children have been adequately described.[1,3,5,6,7] In isolated reports of polycystic disease of the pancreas in adults,[13,8] the symptoms were not of pancreatic insufficiency, but those associated with the presence of tumor in the region of the pancreas, i.e., pain in the upper abdomen of long duration, accompanied by nausea and vomiting. Examination of stools and urine may give no indication of pancreatic disease. Jaundice may result from pressure on the biliary passages or associated hepatic disease.

The possibility that this is a case of cystic fibrosis following pancreatitis cannot be definitely disproved. Cysts resulting from contraction of connective tissue occur at the site of inflammation and are usually found in the head or tail. In this case, as in Gruber's series, the cysts are found in the entire pancreas.

In an attempt to clarify the relation of liver disease to pancreatic disease, the liver lesions in 32 cases of pancreatic disease encountered in 5,500 consecutive autopsies performed at the Institute of Pathology of Western Reserve University have been tabulated. The cases included interstitial fibrosis with or without atrophy of the pancreas, and cystic fibrosis of the pancreas. Of 32 cases with pancreatic disease, 18 or 58 per cent had significant liver disease. Ten had fatty metamorphosis, 6 Laennec's cirrhosis and 2 chronic interstitial hepatitis. In 16 cases of chronic pancreatitis (not diabetic), 10 had significant liver disease, i.e., 4 had fatty metamorphosis, 3 Laennec's cirrhosis, 1 periportal fibrosis, and 2 chronic interstitial hepatitis. Of 4 cases of cystic fibrosis of the pancreas (2 infants, 1 female 7 years old, 1 male 35 years old), 2 had fatty metamorphosis, 1 (7 year female) periportal cirrhosis, and 1 no lesion. In 12 cases of interstitial fibrosis and atrophy of the pancreas (8 diabetic), 4 had fatty metamorphosis (2 diabetics), 1 Laennec's cirrhosis (also diabetic). A control series of 100 autopsies chosen at random from 5,500 autopsies, and covering a similar age group, revealed 20 cases with fatty metamorphosis, 6 cirrhosis (2 cardiac, 2 postnecrotic, 2 Laennec's), and 6 cases with focal necrosis of the liver. Thirty-two of the 100 control cases had some form of liver disease. (Omitting 2 cardiac cases, the corrected figure is 30.) Fatty metamorphosis occurred in one-third of the pancreatic group, and in one-fifth of the control group; cirrhosis or hepatitis occurred in one-fourth of the pancreatic group and one-twenty-fifth of the control group. This latter difference is statistically significant.

These observations suggest that fatty metamorphosis and cirrhosis of the liver in cystic fibrosis of the pancreas and in chronic interstitial pancreatitis with atrophy may be on the basis of pancreatic insufficiency.

SUMMARY

A case of cystic fibrosis of the pancreas in an adult Negro male, 35 years, is presented.

Evidence of the importance of pancreatic insufficiency in the pathogenesis of fatty metamorphosis and cirrhosis of the liver in such cases has been collected.

Note: Since the preparation of this report, an additional case has been observed; a diabetic hypertensive white female, 77 years old, with moderate cystic fibrosis of the pancreas and atrophy and fat infiltration of the liver, who died of generalized severe arteriosclerosis with recent thrombosis of popliteal, splenic, and renal arteries and remote infarcts of brain and heart.

BIBLIOGRAPHY

1. Anderson, D.: Cystic Fibrosis of Pancreas and Its Relation to Celiac Disease. Am. Jr. Dis. Child., 56:344, 1938.

2. Rauch, S., Litwak, A. M., and Steiner, M.: Congenital Familial Steatorrhea with Fibromatosis of Pancreas and Bronchiolectasis. Jr. Pediat., 14:462, 1939.

3. Snelling, C. E., and Erb. I. H.: Cystic Fibrosis of the Pancreas. Arch. Dis. Childhood, 17:220, 1942.

4. Pugh, D.: Fibrocystic Disease of the Pancreas. Am. Jr. Med. Sc., 210:681, 1945.

5. Wolman, I. J.: Cystic Fibrosis of the Pancreas. Am. Jr. Med. Sc., 203:900, 1942.

6. Menten, M. L., and Middleton, T. S.: Cystic Fibrosis of the Pancreas. Am. Jr. Dis. Child., 67:355, 1944.

7. Daniel, W. A., Jr.: Fibrocystic Disease of Pancreas; Report of 8 Cases. Am. Jr. Dis. Child., 64:33, 1942.

8. Carmichael, R. M.: Pancreatic Cysts; Report of 2 Cases. Ohio State Med. Jr., 35:160, 1939.

9. Farber, S.: Pancreatic Function and Disease in Early Life; Pathologic Changes Associated with Pancreatic Insufficiency in Early Life. Arch. Path., 37:238, 1944.

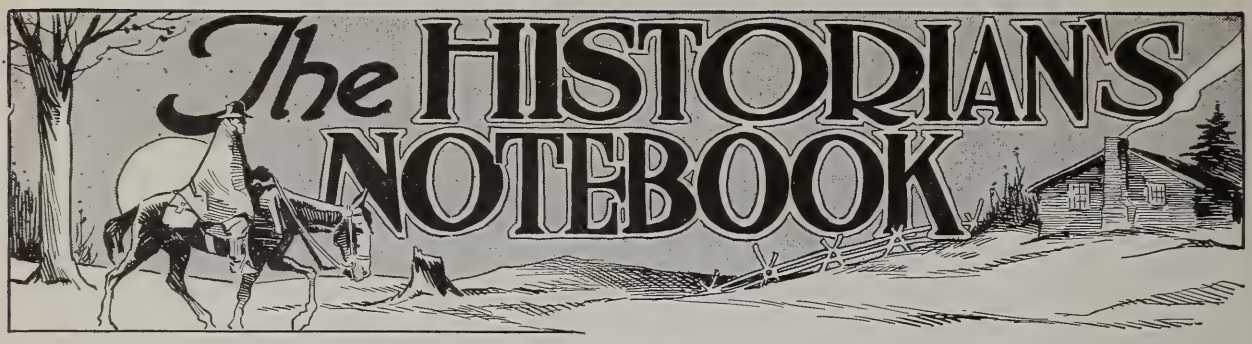
10. Attwood, C. J., and Sargent, W. H.: Cystic Fibrosis of Pancreas with Observation on Roentgen Appearance of Associated Pulmonary Lesions. Radiology, 39:417, 1942.

11. Kaufman, W., and Chamberlin, O. B.: Congenital Atresia of Pancreatic Duct System as a Cause of Meconium Ileus. Am. Jr. Dis. Child., 66:55, 1943.

12. Gruber, G., Henke, F., and Lubarsch, O.: Handbuch Der Speziellen Pathologischen Anatomie und Histologie, Fünfer Band, Zweiter Teil, Berlin, Julius Springer, 284-293, 1930.

13. Nygaard, K. K., and Walters, W.: Polycystic Disease of the Pancreas (Dysontogenetic Cysts); Report of a Case with Partial Pancreatectomy. Ann. Surg., 106:49, 1937.

There are three periods in a woman's life when she is apt to have trouble with her thyroid gland: (1) at puberty, (2) during any pregnancy and (3) at the menopause. If a woman is potentially hyperthyroid, i.e., if she has a goiter that has given evidence of causing trouble before, or if she has a colloid goiter with hidden adenomata within, or a frankly adenomatous goiter, she is in great danger of developing hyperthyroidism at any of these periods.



Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio

Medical Curiosities—Tuberculosis Treatment, 1891

RALPH M. WATKINS, M.D.

AT hand is another pamphlet, "The Treatment of Pulmonary Phthisis", by Thomas D. Coleman, A.B., M.D., read before the Georgia Medical Association in April, 1891. We have come far since those days, yet the respect one feels for the subject of medicine is increased when he reads these old articles. Many of our predecessors were giants of their time, seeking vigorously the truth.

Doctor Coleman's paper is interesting. He reviews and comments on many of the popular treatment methods of his day, many of which our generation has very likely never heard of. Fame is fleeting; if anything could be more fleeting it might be almost any of the so-called tuberculosis "cures" of years ago.

As in previous reviews of these works of older times, occasionally quotations from the text will be used. For a certain pomposity, and some degree of dignity, and at times for a good deal of real literary use of words, they are impossible to match, at least in the publications of today.

In his introduction he speaks of the "cry for more light . . . deep in the mouth of every conscientious groper after truth" and of "the malady . . . a many-headed monster which has vanquished one ambitious victim after another; . . . still very potent and awaits the coming of some medical Hercules, who will not only amputate his many heads, but will as rapidly sear over the stumps with his tubercle destroyer".

Next, Dr. Coleman cites figures of the great mortality from tuberculosis; one-tenth of all deaths in the temperate zone was caused by tuberculosis, and one-seventh in the United States.

PROPHYLACTIC TREATMENT

Aristotle, in the ancient days, knew that tuberculosis was communicable, according to Dr. Coleman, who goes on to cite a few experiments done by himself and others proving that the disease is easily transmitted to animals. Of course, the common development of the disease in those who nurse or attend tuberculous patients is well known. One can not be too careful to avoid contamination. Does the disease attack the foetus? He thinks not but recognizes the disease tendency, so that frequently the child of an infected family will show signs of it in his teens. More likely, babies get it from "oft repeated kissing and fondling" and from the nurse or mother using her personal handkerchief for the baby. The attending physician should never allow a "phthisical nurse" to be employed.

Marriage for a known tuberculous (by the way, the author regularly uses "tubercular") person is a very delicate matter for the doctor to decide. It should not be; however, the doctor often has little to say about it. It is more politic to educate the young people to avoid getting the disease. Dr. Coleman condemns the marriage of a tuberculous woman, contracted expressly in the hope that pregnancy will arrest her disease. "Sir Joseph Clark says it is . . . morally wrong and physically mischievous."

The author approves highly of room ventilation. The "sense of malaise produced . . . by badly ventilated and crowded halls" is not due to the presence of carbonic acid gas (CO_2), "it is due to air vitiated with germs and animal particles exhaled from the lungs of those forming the as-

This is the fourth of a series of "Medical Curiosities" presented by Dr. Watkins. Submitted December 16, 1945.

The Author

• Dr. Watkins, Cleveland, Ohio, is a graduate of Syracuse University College of Medicine, 1920; diplomate, American Board of Internal Medicine; fellow, American College of Physicians; and chief of Medical Service, The Woman's Hospital, Cleveland.

semblage". The prevalence of tuberculosis in prisons is not due to the lack of sunlight and air but the "mental anguish" and lack of laws of cleanliness.

The sputum is the chief source of infection. "The cuspidore (sic) . . . an American invention . . . has turned out to be of public good". Sputum cups of paper had just been suggested by a Russian but a better method "is to use . . . cheese cloth" which can be burned. Window screens and fly papers should be used.

The doctor strongly urges careful meat inspection. This was a law in Germany long before it became one in this country. In this connection he highly praises the Hebrew practice of eating only Kosher meat and states that their inspection rejects 40 per cent of the beeves offered. The rejected carcasses are "often used by Christian butchers".

Sanitation of dairies should be enforced. Pigs had been known to develop tuberculosis after being fed milk from diseased cows.

OCCUPATION

Persons with any hereditary taint should carefully "eschew" the trades of "baker . . . needle grinder, stone mason, quarry men, cotton and wool carders, employment in hemp factories, etc." Frequent excursions to the country are of value. "One of the greatest institutions is . . . Central Park . . . New York's great breathing pore."

CLIMATIC AND HYGIENIC TREATMENT

In those days apparently many Northern patients were sent to the South. Dr. Coleman (who lived in Augusta, Georgia, and should have known) states that these people should not be sent anywhere in the South for some localities were really harmful. For some patients, mountain air is good, for others, sea air. In general, elevated sandy regions in the South are best: St. Augustine, Jacksonville, Tampa, Aiken, Augusta, Thomasville. He recommends also Dr. Karl von Ruck's Sanitorium at Asheville; he actually gives free advertising to Hotel Bon Air, Augusta, "one of the finest and best kept hotels in the South".

The pine forest air is bracing. It may be that the "turpentine given off by the pines converts O into ozone". Patients should wear flannel "from neck to toes" and should never over-exert.

HYDROPATHIC TREATMENT

Daily baths should be taken if the patient is not too debilitated. At first lukewarm, they should gradually be taken cooler. This exercises the "neuropruicular" system of the peripheral arteries.

MEDICINAL TREATMENT

Cod liver oil is valuable, 2 to 6 teaspoonsful after each meal. Its great usefulness is in the considerable nourishment it gives the body. (Vitamins were unknown in those days. It is a wonder that any of the generation survived.) Dr. Coleman quotes a Dr. Williams of England who had proved the value of cod liver oil in a practice of over 40 years. In the early days without cod liver oil, his tuberculous patients lived only 22 months, average, but in the last decade with the oil, their average survival was 8½ years.

Beef tea (he mentions Liebig) is pleasant but not of great food value. Milk should be used in large amounts.

Alcohol, generally, is of value, to be used unless contra-indicated. Digitalis, strophanthus, and iron may be needed. Quinine should be used for "hectic" fever, also antipyretics.

Creosote was very popular in those days. Whether it was the compound or some part of it which did the work, Dr. Coleman did not know. It might be taken by mouth or inhaled, or by a method which would seem to us today to have been painful, to speak mildly; that is, by making up a mixture of 10 grams of creosote in 150 grams of sterilized olive oil and injecting it slowly in the tissues near the scapula. How many patients these days would stand such a heroic injection as that!

Gases: oxygen, sulphurous acid, hydrofluoric acid, carbonic acid, have been tried and abandoned. Rather amusing methods consisted, first, in administering CO_2 by giving the patient soda followed by HCl; second, by enemas of a mixture of CO_2 and H_2S under pressure.

The Hot Air Inhalation treatment, introduced some years before by Louis Weigert of Berlin, is badly criticized by Dr. Coleman. Weigert's idea was to cremate, as it were, the tubercle bacilli in the lungs, without harming the tissue too much. He thought it might be done by exposing them to heat. However, as Dr. Coleman points out, it was physically impossible to heat the air in the lungs to any great degree; the natural cooling powers of the blood prevented that. It seems strange, but it was true, that, even if the inhaled air was warmed to 200° or 300° F., still the exhaled air temperature rose but little above body heat. Doctor Coleman, like others before him, (von Ruck, Trudeau) agrees that the hot air treatment is of no value.

TUBERCULIN

The paper closes with a note on this subject. The writer suspects that Dr. Coleman had had no experience with tuberculin for he has little positive to say; he quoted at some length from others. He says it is unfair for him to judge after such a short time but he fears tuberculin is not the last word in therapy and hopes Dr. Koch will find something better in due time. Koch's discovery of the tubercle bacillus came in 1882, only 9 years before Dr. Coleman's paper.

A Health Program *for* OHIO

Forward-Looking, Affirmative Plan Recommended by House of Delegates of Ohio State Medical Association at Centennial Anniversary Meeting, May 7-9, 1946.

EVERY citizen of Ohio is entitled to an opportunity to achieve and enjoy good health.

Attainment of this goal is possible if a comprehensive, state-wide health program is established and maintained.

It is the earnest desire of the medical profession of Ohio to see such a program developed.

Such a program can be established if:

All groups, agencies and individuals interested in improving the health of the people of Ohio will coordinate their efforts and resources, and,

The people of Ohio are willing to assume certain responsibilities, financial and otherwise, for establishing and maintaining the program.

The Ohio State Medical Association pledges the active support and leadership of the medical profession to this undertaking.

The following proposals, which are fundamental in a sound health program, are suggested as the basis for such a program and have the support of the Ohio State Medical Association.

* * *

1. Economic Improvement.

Efforts should be directed toward general improvement of economic and social conditions in all areas of Ohio. Elevation of living standards, elimination of the causes of unemployment, and removal of economic barriers will have an important bearing on the health of wage earners and their families.

2. Improved Housing.

Improvement in housing conditions is imperative. Programs in operation, or being developed, to eliminate slums and to provide housing conducive to healthful and hygienic living for all, deserve public support generally.

3. Malnutrition.

A concerted attack should be made on the causes of malnutrition, one of the primary causes of ill health. Such a program should consist of efforts to teach people the value of a balanced diet and how to select nutritious food; to improve methods of food distribution; to restore the soil so it can produce nourishing foodstuffs; to raise economic levels so all may have the advantages of nutritious food Presentation of activities to accomplish these objectives, sponsored by health agencies, medical groups, farm and conservation groups, and welfare and civic organizations should be supported and expanded.

4. Sanitation.

Improvement and extension of sanitation safeguards are necessary. Adequate sewage disposal systems, provision of adequate and safe public water supplies, elimination of stream pollution, abolishment of vermin infestation, maintenance of adequate food and milk inspection, supervision of public eating places, health examinations for waiters, barbers and others in direct bodily contact with the public, and similar activities, make large contributions to the individual and public health. State and local public health officials charged with these responsibilities need the support of the public. They should be provided with adequate funds for these functions. If additional legislation is necessary, it should be enacted.

5. Smoke Abatement.

Programs for the abatement of smoke, a nuisance, and cause of economic loss, should be adopted in all communities.

6. Communicable Diseases.

Well-organized and properly-financed programs to prevent and control communicable diseases should be carried on in all communities. This should include adequate programs of immunization and vaccination among preschool and school children. Official health agencies should be provided with adequate funds for this job, working in conjunction with the medical profession, school authorities, and others.

7. Venereal Diseases.

Intensive warfare must be continued against venereal diseases. Health authorities and voluntary agencies in this field should receive widespread public support and the active cooperation of members of the medical profession.

8. Tuberculosis Control.

Efforts to provide Ohio with adequate, modern facilities for the care of the tuberculous and with a program designed to prevent and control tuberculosis warrant the support of all Ohioans. The necessary legislation to accomplish these objectives should be enacted by the next General Assembly.

9. Health Education.

Educational programs on personal hygiene and disease prevention should be expanded. The prevalence of controllable diseases, morbidity and mortalily from preventable causes can be sufficiently reduced if the public is properly and adequately informed, and will cooperate with physicians and health authorities by following their recommendations.

10. Physical Examinations.

The value of periodic health examinations performed by competent physicians should be emphasized and re-emphasized in health education programs. All physicians should prepare themselves to render this service to the public.

11. Cancer and Chronic Diseases.

Agencies sponsoring programs to control cancer and other organic diseases and to provide better facilities for the care of those with chronic ailments should be supported enthusiastically by the public and the medical profession.

12. Mental Disease Program.

Only a start has been made by Ohio in establishing a modern mental hygiene program and adequate facilities for the care and treatment of the mentally ill and mentally deficient. Additional funds to complete the job will be needed and should be supplied by the General Assembly.

13. Rehabilitation of the Handicapped.

Present programs providing care and rehabilitation services for the handicapped and permanently disabled should be expanded, if and when necessary. Sufficient funds for the extension of these services, when needed, should be provided by the state and local governments.

14. Recreation Facilities.

Greater attention should be directed toward improving recreational activities and opportunities for young and old. An adequate recreation program in each community will tend to reduce juvenile delinquency and crime, both of which breed physical and mental diseases. Groups sponsoring such programs deserve public support.

15. School Health Programs.

Many of Ohio's schools need better medical and health programs, including more adequate physical examination procedures and better instruction on matters of health. Greater cooperation between school officials, health authorities and members of the medical profession on this important matter should be established in all school districts.

16. Industrial Health.

Constant efforts should be made to improve working conditions for all wage earners. Sound and properly supervised industrial health programs should be organized in all communities. The responsibility rests jointly on management, labor, the medical profession and official health authorities. Elimination of health hazards in all places of employment, reduction of industrial accidents, and speedy rehabilitation of injured workers are goals toward which these groups should drive.

17. Medical Care for the Needy.

Those who cannot afford the costs of good medical care and hospital services should be furnished such care and services at public expense. This is a dual responsibility of the state and the local governments. Adequate funds for such necessities should be provided. Cooperation between officials charged with this responsibility and members of the medical profession and hospital authorities is essential.

18. State Health Department Services.

Assuming that all citizens of Ohio are interested in the preservation and maintenance of their health, the people of Ohio generally should demand that Ohio's State Department of Health be provided with sufficient funds for the employment of competent personnel and for the maintenance of adequate facilities that proper service may be provided. The department is not receiving adequate appropriations from State funds. This is a serious problem—one which warrants careful study and prompt action by the next General Assembly.

19. Maternal and Child Health Services.

Education and advisory services now being carried on by the state and by local health departments in the field of maternal and child health should be expanded to meet growing needs. State and local funds for

this expansion should be provided. Work of various groups especially interested in such activities should be encouraged. Greater interest should be taken by the medical profession in such programs.

20. Hospital Facilities.

Some areas in Ohio do not have adequate hospital facilities. This situation should be corrected as rapidly as possible through the extension of present hospital facilities or the erection of new institutions. A carefully conducted survey should be made to determine the areas in need of additional facilities. In the event the communities in which the need exists are unable to finance additions to present institutions, or new hospitals, state or federal funds, or both, should be made available.

21. Prepaid Hospital Care Plans.

Extension of voluntary prepaid hospital service plans should be encouraged, as well as hospitalization insurance coverage offered by many reliable insurance companies. At present more than 2,000,000 Ohioans are enrolled in the Blue Cross hospital service plans and many more citizens are covered by insurance contracts providing hospital care. Individuals and families in the middle and lower income groups not now protected against the costs of hospitalization should be encouraged to secure such benefits which are available for moderate monthly payments.

22. Prepaid Medical Care Plans.

Protection against the costs of medical care is available to Ohio wage earners and their families. Such protection may be secured by making moderate monthly payments to health, accident and casualty insurance companies. Of special interest is the organization of a medical indemnity company by the medical profession of Ohio to meet a particular demand and need for a program whereby wage earners may budget the costs of medical care for themselves and their dependents on an insurance basis. Ohio Medical Indemnity, Inc., the "Doctors' Plan", is operating successfully in one area of the state and will expand its activities to other communities as rapidly as feasible. These voluntary methods which have been established to give Ohio's citizens an opportunity to protect themselves against some of the financial hazards of illness and disability should be supported and encouraged.

23. Care of Disabled Veterans.

Public support should be accorded programs being established to provide veterans with service-connected disabilities, with the best of medical care. Plans have been developed by the Ohio State Medical Asosciation in cooperation with the Veterans' Administration and veterans' organizations to provide the disabled veteran with an opportunity to receive care at government expense from physicians in his own community. Similar plans whereby the disabled veteran may receive hospital care in civilian hospitals in his own community are being worked out. These programs should be encouraged as they will make it possible for the veteran to receive his medical and hospital care from competent physicians and efficiently operated hospitals of his own choice and in his home town.

24. Rural Health.

The medical profession and farm organizations are endeavoring to find the solution for existing health problems in rural areas of Ohio. Public support should be given to these activities. Adequate services and facilities are not available now in many rural sections of the state. Such

services and facilities should be supplied. Some rural areas do not have an adequate number of physicians. Increased efforts should be made to attract physicians to such areas.

A concerted attack should be made on some of the basic problems of rural health. Stronger and better financed local health departments better able to provide adequate services, are needed in many rural areas. Improvement in sanitation is imperative. Better programs for the control of communicable diseases are required. Good health education programs should be initiated. Many of these activities are questions of local responsibility and local administration but assistance from the state should be made available where local communities are unable to meet adequately all of the problems which arise.

25. Medical Education.

The youth of Ohio who desire to enter the profession of medicine as a career should be provided with opportunities to receive such an education. Expansion of Ohio's three medical schools will be necessary to meet increasing demands. Their efforts to expand and to improve their facilities should have the support of the public. Also, Ohio physicians should be provided with opportunities for regular postgraduate training so they may keep abreast of advances in the medical and closely allied sciences. Activities of our medical schools and hospitals in the field of postgraduate education should be encouraged. The postgraduate education facilities of the Ohio State Medical Association are being expanded for the benefit of the Association's 7,000 members.

* * *

Obviously, revolutionary procedures will not be necessary to inaugurate in Ohio a health program embodying the foregoing recommendations.

Safe and sane cooperation between the public, the government, unofficial agencies and members of the medical profession will do the job.

Many of the activities suggested can be carried on by alert voluntary organizations, working with the medical profession and health authorities.

Some of the programs recommended will have to be carried on by official local and state health agencies. Strengthening of local health departments will accomplish much.

In some instances, the cooperation and assistance of the Federal government will be needed. **However, for the most part, participation by the Federal government can be confined to an advisory role or in aiding on problems which are inter-state in scope.**

Ohio with its wealth and ability is capable of providing such a program for its citizens. **A so-called "national health program" such as the one recommended to the Congress is not needed. Ohio can meet these responsibilities, if it will do so.**

However, more than lip-service will be required. **There must be action and a will to meet financial responsibilities on the part of the people of Ohio.**

The medical profession of Ohio not only pledges its support of an adequate health program for the State, but calls on the people of Ohio to join it in making such a program a reality.

OHIO PLAN WHERBY DISABLED VETERANS MAY RECEIVE MEDICAL CARE FROM HOME-TOWN DOCTORS APPROVED BY VETERANS ADMINISTRATION; WILL BECOME EFFECTIVE JULY 1

The Ohio State Medical Association's program whereby veterans with service-connected disabilities may receive medical care from home-town physicians of their own choice has been approved by the Veterans Administration and WILL BECOME EFFECTIVE JULY 1. It will be administered by Branch Office No. 6 of the Veterans Administration, Columbus, and the two Ohio regional offices of the Veterans Administration, under the supervision of Dr. Neville H. McNerney, medical director of Branch Office No. 6, which has jurisdiction over Ohio, Michigan, and Kentucky.

Within the next few weeks, literature setting forth details of the program and the fee schedule will be mailed to each member by the Ohio State Medical Association.

Administrative details are now being worked out and will be explained in the folder which is being prepared.

All members of the Association will be given an opportunity to sign up for participation in the program.

Those who desire to participate will be appointed fee-designated physicians and will be paid by the Veterans Administration for services rendered in authorized cases in accordance with the fee schedule submitted by the Ohio State Medical Association and approved by the Veterans Administration.

Watch for this special mailing which will go to all members and for more complete information in the July issue of The Journal.

Those desiring to participate should sign promptly the application blank which will be sent to members so their names can be placed on the lists of designated physicians which will be filed with the Veterans Administration.

Dr. Towey To Head Tuberculosis Program of V. A. in Three-State Area

Dr. John W. Towey of Powers, Mich., medical superintendent of Pine Crest Sanitarium at Powers for the last 25 years, has been appointed Chief of the Tuberculosis Division for Branch Office No. 6 of the Veterans Administration located at Columbus.

Dr. Towey, veteran of the first World War, will be responsible for all technical and administrative aspects of the tuberculosis program in Veterans Administration hospitals of the Branch Office area, embracing Ohio, Michigan, and Kentucky.

A graduate of Winona, Minn., High School in 1908, Dr. Towey received his degree in medicine from Northwestern University in 1914. He is a member of Menominee County (Mich.) Medical Society, Michigan State Medical Society, American Medical Association, American College of Physicians, and the American Legion.

Dr. Hopwood Named Superintendent of Cambridge State Hospital

Dr. Arthur T. Hopwood, formerly superintendent of the Apple Creek State School in Wayne County, is now superintendent of the State's recently acquired Fletcher Hospital at Cambridge.

Dr. Everett F. Clouse, previously on the medical staff of the Columbus State Hospital, replaces Dr. Hopwood as superintendent of the Apple Creek institution.

Fletcher Hospital, which in the future will be known as the Cambridge State Hospital, will be established as a training center for state hospital personnel. Dr. Hopwood, together with members of the staff of the State Division of Mental Hygiene, is working out an intensive training course for state hospital attendants which will be either one or two weeks in duration with provisions for refresher courses for personnel already in service. The course will include lectures, discussions, clinical observations, motion pictures, and other training techniques.

Official Proceedings of the House of Delegates, Ohio State Medical Association, Centennial Anniversary Meeting, Columbus, May 7-9, 1946

MINUTES OF THE FIRST SESSION

THE Centennial Anniversary Meeting of the Ohio State Medical Association was opened with a meeting of the House of Delegates on Tuesday, May 7, 1946, 10:00 A.M., Neil House, Columbus, Ohio.

The meeting was called to order by Dr. Horace B. Davidson, president of the Columbus Academy of Medicine and general chairman of the local committees on arrangements. Dr. Davidson welcomed the delegates and offered the hospitality of the Columbus profession. He then introduced the President, Dr. L. Howard Schriver, Cincinnati, and at that point, Dr. Schriver made his Presidential Address. (See page 639 in this issue.)

The roll of delegates was called, 115 being present.

President Schriver asked for action on the minutes of the meetings of the House of Delegates held in 1944. (No Annual Meeting was held in 1945.) On **motion** by C. C. Sherburne, Franklin County, seconded by James A. Beer, Franklin County, and **carried**, the minutes **were approved** as published in the June, 1944, issue of *The Ohio State Medical Journal.*

REFERENCE COMMITTEES APPOINTED

Six reference committees were appointed by President Schriver as follows:

Resolutions—Carll S. Mundy, Toledo, chairman; Robert Conard, Wilmington; M. D. Prugh, Dayton; J. Craig Bowman, Upper Sandusky; Farrell T. Gallagher, Cleveland; Wm. M. Skipp, Youngstown; Jay W. Calhoon, Uhrichsville; Arthur J. Tronstein, Newark; George G. Hunter, Ironton; George J. Heer, Columbus; John S. Hattery, Mansfield.

Annual Reports—Chas. W. Pavey, Columbus, chairman; R. Dean Dooley, Dayton; Frank M. Wiseley, Findlay; R. E. Pinkerton, Akron; Geo. M. Emery, Ashland.

Presidential Address—D. W. Heusinkveld, Cincinnati, chairman; H. A. Kerns, Kenton; D. J. Slosser, Defiance; R. D. Herlinger, Warren; Charles R. Meek, Lorain.

Credentials—A. R. Basinger, North Canton, chairman; D. C. Houser, Urbana; James A. Beer, Columbus.

Tellers and Judges of Election—Ralph W. Holmes, Chillicothe, chairman; D. G. Arnold, Bucyrus; Marlin R. Wedemeyer, Oak Hill; V. A. Killoran, Sandusky.

Time and Place of 1947 Annual Meeting—Edgar P. McNamee, Cleveland, chairman; Emil R. Swepston, Cincinnati; Roy C. Hunter, Wapakoneta; Drew L. Davies, Columbus; F. C. Ganyard, Wooster.

At this point the President referred to the Reference Committee on Annual Reports the annual reports of the standing and special committees published in the April, 1946, issue of *The Ohio State Medical Journal.* No supplemental reports of committees were presented.

NOMINATING COMMITTEE ELECTED

Nomination of representatives of the eleven Councilor Districts for the Committee on Nominations was then called for by President Schriver.

The following delegates were nominated and elected to the Committee on Nominations:

First District—Emil R. Swepston, Cincinnati.
Second District—M. R. Haley, Dayton.
Third District—J. R. Johnson, Lima.
Fourth District—R. C. Young, Toledo.
Fifth District—Farrell T. Gallagher, Cleveland.
Sixth District—John M. Van Dyke, Canton.
Seventh District—Carl F. Goll, Hopedale.
Eighth District—W. E. Radcliff, Caldwell.
Ninth District—R. E. Boice, Middleport.
Tenth District—James A. Beer, Columbus.
Eleventh District—Ross M. Knoble, Sandusky.

RESOLUTIONS INTRODUCED

The next order of business was the introduction of resolutions.

The following resolutions were read by the Executive Secretary and presented at the request of The Council to the House of Delegates:

Resolution A

For text of this resolution entitled "A Health Program for Ohio" see page 620, this issue.

Resolution B

WHEREAS, There is a need for improvement in and extension of the activities of the Ohio State Medical Association, especially in the field of public relations, and

WHEREAS, Satisfactory handling of the public relations, legislative activities, and other functions of the Association for the benefit of the entire medical profession of the state will depend on the maintenance of a competent public relations staff, on securing competent outside public relations counsel when necessary, and on the use of such media as the press, radio, and a well-organized speakers' bureau, and

WHEREAS, It is the responsibility of the Ohio State Medical Association to head up these activities in Ohio, to cooperate with the American Medical Association in meeting national problems of vital importance to the

medical profession, and to assist local medical societies in maintaining proper public contacts, and

WHEREAS, There also are additional programs, activities, and services which should be undertaken by the Ohio State Medical Association for the benefit of its members, such as those summarized in a statement issued by The Council and published in the March, 1946, issue of *The Ohio State Medical Journal*,

BE IT RESOLVED, That the annual per capita dues of the Ohio State Medical Association shall be increased from $7.00 to $15.00, effective January 1, 1947, for the purpose of providing the Association with funds for carrying out the objectives referred to above.

Resolution C

WHEREAS, The Emergency Maternal and Infant Care Program instituted by the United States Children's Bureau was established for the purported purpose of meeting conditions arising solely from the war emergency, and

WHEREAS, Such emergency no longer exists and there is no public need for such activity on the part of the Federal Government, and

WHEREAS, Conversion of the E.M.I.C. plan into a permanent program, such as the one proposed in Senate Bill 1318 now pending in Congress, would establish a costly and bureaucratic system of medical service, controlled and regulated by the Federal Government and supported by tax funds, and

WHEREAS, The proposed program would provide medical care at public expense for every pregnant woman and every child under 21 years of age, regardless of their financial circumstances, and

WHEREAS, Such a system of politically-controlled medical care would result in a lowering of the standards of medical service, would be wasteful of public funds, would interpose a third party between patients and doctor, would centralize control in the hands of a Federal bureau which has in the past used dictatorial tactics, and would make more than half the population virtually wards of the Federal Government, and

WHEREAS, A program such as the one proposed in Senate Bill 1318 is not needed in Ohio where mothers and children always have received, and will continue to receive, adequate medical care of the highest quality from their own physicians through direct arrangements with such physicians or through official state or local health-welfare agencies in event financial assistance is needed,

BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association shall request termination of the present E.M.I.C. Program at the close of the present fiscal year of the Federal Government—June 30, 1946—and shall voice its disapproval of Senate Bill 1318 or any like proposal.

BE IT FURTHER RESOLVED, That a copy of this resolution shall be sent to each Ohio member of the United States Congress.

Resolution D

BE IT RESOLVED, That the By-Laws of the Ohio State Medical Association be amended to read as follows:

In Chapter 4, Sec. 4, strike out the words "Committee on Annual Reports;".

In Chapter 9, Sec. 7, strike out the words "Annual reports must be in the hands of the Executive Secretary at least sixty days prior to the annual meeting of the Association and shall be published in *The Journal* at least one month before the annual meeting of this Association." and in lieu thereof, substitute the following "Such committees shall submit reports from time to time to The Council for its consideration and for publication in *The Journal* in order that the membership may be informed of the work of such committees".

Resolution E

R. L. Rutledge, Alliance, introduced the following resolution on behalf of the Stark County Medical Society

RESOLVED, That especially during recent war years, irregular practitioners of medicine have been practicing illegally and reaping a harvest, due to the absence of many of our physicians who have been in the service of their country.

SECOND, BE IT RESOLVED, That due to the lack of vigilance of the board of examiners and of members of our organization, generally, in not reporting violations, these irregular practitioners are getting farther and farther out of bounds.

THEREFORE, BE IT FURTHER RESOLVED, That the House of Delegates take proper and careful action to remedy this condition.

Resolution F

A resolution was presented on behalf of the Mahoning County Medical Society by William M. Skipp, Youngstown. The resolution read as follows:

BE IT RESOLVED by the Ohio State Medical Association, that

WHEREAS, For a number of years intern service in our hospitals has frequently been unsatisfactory to the patient, the hospital, and the medical staff, and

WHEREAS, Hospitals have been handicapped in enforcing their rules and regulations governing interns, due to the fact that dismissal for gross infractions of the rules was meaningless because a satisfactory completion of the internship is not a necessary prerequisite to the practice of medicine, and

WHEREAS, This condition is country wide;

NOW, THEREFORE, The Ohio State Medical Association, hereby recommends to the Ohio State Board of Medical Licensure, and the Federation of State Medical Boards of the United States, that a twelve months' internship in an accredited hospital be required of a candidate before such candidate be granted license to practice medicine and surgery;

AND FURTHERMORE, It is recommended to the Association of American

Medical Colleges and to the Council on Medical Education and Licensure, that a twelve months' internship in an accredited hospital be required before a diploma of graduation from medical school be granted; and that this resolution be presented by the Ohio State Medical Association to the House of Delegates of the American Medical Association in San Francisco, July 1-5, 1946.

Resolution G

V. A. Killoran, Sandusky, presented the following resolution on behalf of the Erie County Medical Society:

WHEREAS, There has been a gradual increase in the number of cases of contagious disease, and

WHEREAS, There has been a gradual decrease in the immunization of children, and

WHEREAS, Local authorities often find it difficult or impossible to enforce compulsory immunization,

THEREFORE, BE IT RESOLVED, That the Erie County Medical Society recommends to the House of Delegates of the Ohio State Medical Association in convention May 7 and 8, 1946, that an effort should be made to have legislation passed making immunization compulsory for grade school entrance;

AND BE IT FURTHER RESOLVED, That the Ohio State Medical Association do not sponsor this legislation, but make an effort to have the State Department of Health or some other health-minded organization do so.

Resolution H

The following resolution was introduced by Arthur J. Tronstein, Newark, on behalf of the Licking County Medical Society:

WHEREAS, The proper management of cases of primary syphilis depends upon proper diagnosis of the lesion. Furthermore, early in the course of primary syphilis the various accepted tests upon the blood are negative, therefore the proper diagnosis depends upon positive identification of the infecting spirochete by darkfield examination.

FURTHERMORE, The proper management of any case of syphilis requires that a study of the spinal fluid be made at stated intervals during the treatment or at its supposed completion.

THEREFORE, BE IT RESOLVED, That the Licking County Medical Society shall ask the Ohio State Medical Association to request the Department of Health of the State of Ohio to require all physicians, clinics, hospitals, etc., authorized to treat or diagnose primary syphilis to show that a proper darkfield examination was performed upon all cases reported as being primary syphilis, and that the Department of Health shall pay the reporting individual or group a fee of five dollars ($5.00) for this service.

FURTHERMORE, BE IT RESOLVED, That in like manner the Department of Health, in addition to the fees it now pays for the administration of anti-luetic therapy, shall pay the sum of five dollars ($5.00) for each spinal fluid study performed upon the patient whose therapy it authorizes. It shall be understood that the Department of Health may require such information as it desires concerning the spinal fluid specimen and may limit payment for such spinal fluid studies to not over three times for any one patient.

Resolution I

Dr. Tronstein also introduced the following resolution:

WHEREAS, Each day the physician is called upon to complete numerous claim blanks for patients seeking benefits from insurance companies, lodges, fraternal funds, political subdivisions, etc., under contracts for health, accident or death benefits. And furthermore, it is seldom that the attending physician receives compensation for his time consumed in filing these numerous blanks or for his professional judgment needed in so doing

THEREFORE, BE IT RESOLVED by the Licking County Medical Society, That the Ohio State Medical Association shall issue to its members or any other licensed medical doctor in the State of Ohio simple, but adequate forms for filing claims for accident, health or death benefits, respectively; and that these above-named forms shall bear notice from The Ohio State Medical Society that should more than two such forms be desired for one claim, or that shall the insurer desire further information not contained in these forms, then the attending physician will comply with such requests only at the expense of the insurance company, fraternal organization, or other insurer so desiring the additional forms of information. The only exception to this procedure shall be in the filing of claims for the Industrial Commission of the State of Ohio.

Resolution J

A resolution from the Montgomery County Medical Society was introduced by R. S. Binkley, Dayton. It read as follows:

WHEREAS, The physicians engaged in the general practice of medicine comprise a larger numerical group than any other group of physicians in any of the specialty sections,

AND WHEREAS, There are problems peculiar to the general practice of medicine whose solution can best be accomplished by those men to whom they relate,

AND WHEREAS, Scientific programs of specific interest to those in the general practice of medicine are too seldom seen, and because this situation could best be corrected by those most concerned, the general practitioners;

THEREFORE, BE IT RESOLVED, That the delegates of the Montgomery County Medical Society to the Ohio State Convention offer and sponsor a motion for the creation of a General Practice Section of the Ohio State Medical Association.

REFERRED TO COMMITTEE

The foregoing resolutions were automatically referred by the President to the Reference

Committee on Resolutions for study and a report back to the House of Delegates at the next session of the House of Delegates scheduled for Wednesday, May 8, 9:00 A.M.

INVITATION FROM CLEVELAND

Farrell T. Gallagher, president of the Cleveland Academy of Medicine, presented an invitation on behalf of the Cleveland Academy of Medicine and the Cleveland Chamber of Commerce that the Ohio State Medical Association hold its 1947 meeting in Cleveland.

The invitation was referred by the President to the Reference Committee on Time and Place for 1947 Annual Meeting.

GUESTS PRESENTED

At this point President Schriver introduced Dr. Charles N. Coombs of Terre Haute, Indiana, chairman of the centennial anniversary committee of the Indiana State Medical Society, and Mr. Ray A. Smith, Executive Secretary of the Indiana State Medical Society. Dr. Schriver welcomed Dr. Coombs and Mr. Smith and extended to them the best wishes and hospitality of the Association.

There being no further business, the House of Delegates then recessed to meet at 9 A.M., Wednesday, May 8.

MINUTES OF THE SECOND SESSION

The second session of the House of Delegates was called to order by President Schriver at 9:00 A.M., May 8, 1946, Neil House, Columbus, Ohio.

The roll call showed 119 delegates present.

Reports of the Reference Committee were called for by the President.

REPORT OF COMMITTEE ON PRESIDENTIAL ADDRESS

The following report of the Reference Committee on Presidential Address was read by D. W. Heusinkveld, Cincinnati, chairman of the reference committee, and **was adopted** by the House of Delegates on **motion** by Dr. Heusinkveld, seconded by William M. Skipp, Mahoning County, and **carried:**

"Your committee, after thorough consideration of the President's address, respectfully submits the following report:

"The Ohio State Medical Association has been most fortunate in having been guided in the last two, and perhaps most difficult, years of its century of service to the medical profession and the people of Ohio. The energy, ability, faithfulness, and philosophy of Dr. Schriver enables the Association to close its first century with record accomplishments.

"Mindful that history's greatest war has been brought to a successful conclusion, due in no small way to the glorious accomplishments of the medical profession in the Service, a cordial welcome is extended to the returned service men.

"The advances made in the century just now closing have raised the American standard of living beyond the imagination of the most optimistic minds of one hundred years ago.

"For the present, uncertainty, confusion, and unhappiness prevail. Individual freedom has been curtailed. Efforts have been made to sabotage democracy; to take from the Medical Profession its democratic freedom and to replace it with regimentation and bureaucratic control.

"Looking forward, we are urged to prevent the passage of proposed legislation such as the Wagner-Murray-Dingell Bill with its destructive effects on medical services generally, by accepting the responsibility of informing an interested public, as physicians individually and collectively as the medical profession.

"By creating Ohio Medical Indemnity, Inc., the Ohio State Medical Association has met its responsibility in the nationwide effort being made to provide all with an opportunity to participate in voluntary, prepaid medical care programs. Through this, and similar programs, medical care will retain its superlative character in contrast to the mediocrity, inefficiency, dishonesty, red tape, neglect, and excessive costs which always have been characteristic of politically controlled plans.

"Looking forward to improved medical practice and to the constantly increasing functions of the Ohio State Medical Association, two recommendations are presented:

> "1. Discontinuance of the Emergency Maternity and Infant Care program because it has ceased to be a governmental activity. It is not in harmony with the principles of the practice of medicine by free men, and it is a forerunner of a plan to federalize all mothers and children in America.
>
> "2. To cover the cost of the constantly increasing functions of the Ohio State Medical Association, an increase in the annual per capita dues from $7.00 to $15.00 to become effective January 1, 1947.

"Your committee heartily endorses these recommendations; we commend this able review of the problems that confront the medical profession at this time; for all of it we ask your thoughtful consideration."

REPORT OF COMMITTEE ON ANNUAL REPORTS

George M. Emery, Ashland County, presented the report of the Reference Committee on Annual Reports on behalf of Charles W. Pavey, chairman of that committee, who was unable to be present at this session of the House of Delegates; and such report **was adopted** on **motion** by Emil R. Swepston, Hamilton County, seconded by E. O. Swartz, Hamilton County, and **carried:**

"The Reference Committee on Annual Reports submits herewith, for consideration by the House of Delegates, abstracts of reports submitted by the various committees of The Ohio State Medical Association. The full reports are available for study in the April, 1946, issue of *The Ohio State Medical Journal.*

"**Committe on Public Relations and Economics:** This committee during its term has investigated candidates for public office and familiarized the membership with their records and attitudes on matters pertaining to health and medical practice. They have also familiarized legislators with our attitudes toward health and medical legislation under consideration with the result that of 50 such bills introduced into the State Legislature,

a number of valuable measures were passed and all that were detrimental were rejected.

"In the field of Federal legislation publicity campaigns were organized in opposition to the Wagner-Murray-Dingell Compulsory Sickness Insurance Bill. This campaign included public addresses, distribution of pamphlets, and notification of our elected representatives of our opposition. The committee also recommended to and received from Council official condemnation of the Pepper Bill which in effect extends the Federal Emergency Maternal and Infant Care Program to all classes of citizens.

"On the positive side the committee has endorsed the Hill-Burton Hospital Building measure, S. 191, the reorganization of The Veterans' Bureau, and proposals for elimination of stream pollution in the Ohio Valley. The Committee was also instrumental in speeding up demobilization of medical personnel following the end of the war.

"In the field of State legislation the committee supported the plans for expansion and improvement of the Mental Hygiene and Tuberculosis Control Programs.

"Cooperation, assistance, and advice was given the Ohio Department of Education on the subject of health education and school health programs. Similar service was rendered The Ohio Division of The American Cancer Society with respect to literature for public distribution and policies governing projected diagnostic clinics. The committee also made suggestions and criticisms concerning the wording of Blue Cross contracts keeping them in line with the standing policies of the State Medical Association particularly as regards exclusion of professional services.

"The health and medical problems of rural areas have been discussed with representatives of farm groups and the matter referred for more detailed consideration to a special committee appointed by President Schriver.

"The State Association is represented on the Governor's Commission on Hospital Care and the committee has taken an active interest in its proposed survey of hospital and health facilities.

"In regard to mass chest surveys for public health purposes, the Committee on Public Relations drafted the policy requiring approval of local medical societies, examination of films by competent physicians, referral of cases requiring further study to local physicians and local determination of the fee question.

"The committee recommended to Council and received approval of the plan involving a radio hookup for programs of several Midwestern State Medical Societies.

"Frequent conferences with the State Directors of Health and Welfare are also reported and the report outlines the reorganization and reactivation of the Public Relations Department of the State Association.

"In closing the committee recommends the contemplated increase in annual dues to the State Association.

"The Committee on Medical Service Plans reports the organization of a voluntary prepaid medical care plan for Ohio. This plan is at present operating in 14 Southwestern Ohio counties and uses the administrative facilities of Blue Cross. They report 5,000 contracts covering 12,500 individuals. The plan calls for conservative operation with expansion to other parts of the State as experience is acquired. The Committee reminds us that this is our answer to the proponents of governmental medicine and that its success will depend upon the manner in which we use it.

"Committee on Education: The Committee on Education has been busy with three aspects of postgraduate instruction: One: Steps to revive the postgraduate lectures of the OSMA; Two: a program for refresher facilities for medical veterans and; Three: a campaign to expand the residency facilities for the benefits of veterans. The committee has also participated in educational campaigns on cancer, rapid treatment of syphilis, and matters of health and health education in the public schools.

"Committee on War Participation: This committee has thankfully laid down its responsibilities with the end of the war. It has performed a meritorius service to the armed forces, the civilian population, and the profession in its efforts to make the fairest possible distribution of medical personnel. The committee has functioned fairly and efficiently and has earned the thanks of both the public and the profession.

"Committee on Medical Care of Veterans: This committee was created to represent the medical profession in assisting the Veterans' Administration in providing a program for medical care of veterans with service-connected disabilities. Its important activities to date consist of:

"1. Requesting each county to establish a similar committee to handle local details of such matters under agreement with the Veterans' Administration. To date over half the counties have such committees.

"2. Requesting from each county a list of physicians willing to examine veterans applying for disability compensation.

"3. Advising the Veterans' Administration on the qualifications of specialists.

"4. Submission to the Veterans' Administration of a proposed agreement for a state-wide program to enable veterans to receive medical care from physicians of their own choice.

"5. Formulation of a proposed fee schedule patterned after Workmen's Compensation fees.

"6. Conferences with Veterans' Administration representatives to work out details of the program.

"The committee feels that the Veterans' Administration has been highly cooperative in establishing a program that will assure veterans good medical care within the structure of private medicine. Provision has been made for periodic revisions in the program.

"It is emphasized that this program gives the profession its opportunity to prove that a huge institutionalized, socialized program is not necessary.

"Sub-Committee on Workmen's Compensation: This committee was etablished to negotiate with the Industrial Commission changes in the rules governing medical procedures and fees in Workmen's Compensation claims. Revised rules and fees were adopted as of May 1, 1945. The committee feels that the new rules and fees represent substantial progress and the way remains open and efforts will be continued to further correct and improve the present setup.

"Committee on Auditing and Appropriations: The annual audit indicates that the Association is solvent and that its affairs have been conducted in a businesslike manner. It is apparent that present revenues allow no margin for contemplated expansion of activities. There is before the House of Delegates at this session a recommendation from Council to increase the

annual dues from $7.00 to $15.00, an action that will have to be approved if the State Association is to expand to meet the exigencies now confronting the profession."

REPORT OF COMMITTEE ON TIME AND PLACE OF ANNUAL MEETING

E. P. McNamee, Cuyahoga County, chairman of the Reference Committee on Time and Place of 1947 Annual Meeting, reported that his committee had met and considered the invitation of the Cleveland Academy of Medicine. He stated that his committee recommended that the Cleveland invitation be accepted, providing suitable facilities are available, and that if this is the case, the Association hold its next meeting in Cleveland in the Spring of 1947.

On **motion** by Lewis W. Cellio, Carroll County, seconded by D. A. Berndt, Scioto County, and **carried** the recommendation of the Reference Committee was **adopted.**

REPORT OF RESOLUTIONS COMMITTEE

Carll S. Mundy, Lucas County, presented the report of the Reference Committee on Resolutions, reading as follows:

"The Reference Committee on Resolutions has given careful consideration to the resolutions introduced into the House of Delegates on Tuesday, May 7, and referred to this committee for study and recommendations. The committee has listened to arguments pro and con on the respective resolutions. It presents the following report and recommendations:

RESOLUTION A

"The first question referred by the House of Delegates to this committee was "A Health Program for Ohio", which had already been approved by The Council and which was referred to the House of Delegates for action. **(See page 620 for text of program.)**

"Many members of the State Association have long felt that we, as an organized group, should actively sponsor a program for the improvement of public health. This program which has been offered by your Council meets this need.

"Your reference committee unanimously endorses the program, copies of which have been distributed to members of the House of Delegates, and **recommends its adoption.**"

On **motion** by Dr. Mundy, seconded by F. N. Nagel, Lucas County, and **carried**, the recommendation of the reference committee on Resolution A **was adopted.**

RESOLUTION B

"Resolution B was submitted to the House of Delegates by The Council. It proposes an increase in the annual per capita dues of the Ohio State Medical Association from $7.00 to $15.00, effective January 1, 1947. Copies of the resolution and an explanatory statement by The Council were distributed to members of the House of Delegates at yesterday's session.

"It is obviously necessary for the State Association to have adequate funds with which to implement activities which should and must be undertaken by the Association.

"The reference committee therefore **recommends the adoption of Resolution B as presented.**"

On **motion** by Dr. Mundy, seconded by R. C. Young, Lucas County, and **carried**, the recommendation of the reference committee on Resolution B **was adopted.**

RESOLUTION C

"Members of the House of Delegates yesterday were provided with copies of this resolution which was presented on behalf of The Council.

"Your reference committee is in thorough agreement with the resolution as presented. However, the committee feels that the Ohio State Medical Association should support on a state and local basis a program of activities some of which are contemplated in Senate Bill 1318. Therefore, your committee recommends that the original resolution be amended by the insertion of the following:

"BE IT FURTHER RESOLVED, That the Ohio State Medical Association, its component societies, and its individual members take an active part and interest in supporting and improving existing facilities in Ohio to provide proper maternal and child health and medical services for the women and children of our state.

"Your reference committee **recommends that the House of Delegates adopt the resolution as amended** and reading as follows:

> "WHEREAS, The Emergency Maternal and Infant Care Program instituted by the United States Children's Bureau was established for the purported purpose of meeting conditions arising solely from the war emergency, and
>
> "WHEREAS, Such emergency no longer exists and there is no public need for such activity on the part of the Federal Government, and
>
> "WHEREAS, Conversion of the E.M.I.C. plan into a permanent program, such as the one proposed in Senate Bill 1318 now pending in Congress, would establish a costly and bureaucratic system of medical service, controlled and regulated by the Federal Government and supported by tax funds, and
>
> "WHEREAS, The proposed program would provide medical care at public expense for every pregnant woman and every child under 21 years of age, regardless of their financial circumstances, and
>
> "WHEREAS, Such a system of politically-controlled medical care would result in a lowering of the standards of medical service, would be wasteful of public funds, would interpose a third party between patients and doctor, would centralize control in the hands of a Federal bureau which has in the past used dictatorial tactics,

and would make more than half the population virtually wards of the Federal Government, and

"WHEREAS, A program such as the one proposed in Senate Bill 1318 is not needed in Ohio where mothers and children always have received, and will continue to receive, adequate medical care of the highest quality from their own physicians through direct arrangements with such physicians or through official state or local health-welfare agencies in event financial assistance is needed,

"BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association shall request termination of the present E.M.I.C. Program at the close of the present fiscal year of the Federal Government—June 30, 1946—and shall voice its disapproval of Senate Bill 1318 or any like proposal.

"BE IT FURTHER RESOLVED, That the Ohio State Medical Association, its component societies, and its individual members take an active part and interest in supporting and improving existing facilities in Ohio to provide proper maternal and child health and medical services for the women and children of our state.

"BE IT FURTHER RESOLVED, That a copy of this resolution shall be sent to each Ohio member of the United States Congress."

On **motion** by Dr. Mundy, seconded by Joseph Bolin, Hamilton County, and **carried**, the recommendation of the reference committee on Resolution C was **adopted.**

RESOLUTION D

"This resolution, also submitted by The Council, proposes an amendment to the By-Laws of the Ohio State Medical Association. The change suggested would eliminate the requirement for annual reports by the various committees of the Association, but on the other hand, would incorporate in the By-Laws a provision requiring such committees to submit reports periodically to The Council for its consideration and for publication in *The Journal.*

"Your committee recommends the **adoption of the proposed amendment**, believing that the change will improve methods of keeping the the membership properly and promptly informed of the activities of the various committees."

On **motion** by Dr. Mundy, seconded by Ralph W. Holmes, Ross County, and **carried**, the recommendation of the reference committee on Resolution D was **adopted.**

RESOLUTION E

"Resolution E, presented by R. L. Rutledge, Alliance, on behalf of the Stark County Medical Society, read as follows:

"RESOLVED, That especially during recent war years, irregular practitioners of medicine have been practicing illegally and reaping a harvest, due to the absence of many of our physicians who have been in the service of their country.

"SECOND, BE IT RESOLVED, That due to the lack of vigilance of the board of examiners and of members of our organization, generally, in not reporting violations, these irregular practitioners are getting farther and farther out of bounds.

"THEREFORE, BE IT FURTHER RESOLVED, That the House of Delegates take proper and careful action to remedy this condition.

"This resolution was discussed at length by your committee. Consultations were held with Dr. J. H. J. Upham, member of the State Medical Board, and Dr. H. M. Platter, secretary of the Board.

"The committee was informed that the State Medical Board has only two inspectors to cover the entire state and in the past year these two inspectors have investigated some 800 cases. Also, the committee was advised that the State Legislature has not seen fit to appropriate sufficient funds for carrying on the work of the State Medical Board.

"As the situation exists at the present time, enforcement of the Ohio Medical Practice Act is primarily a function and responsibility of local law enforcement agencies. Obviously, unless there is a sufficient public demand in all counties, enforcement and prosecutions will not be vigorous and offenders will go unpunished.

"Your committee is in accord with the intent of the original resolution, but because of the facts submitted to it during its deliberations, the committee suggests that the resolution be re-worded.

"Therefore, the **committee submits the following substitute resolution and recommends its adoption:**

SUBSTITUTE RESOLUTION E

"WHEREAS, Violations of the Medical Practice Act are increasing, and

"WHEREAS, This is tending to destroy the public health safeguards which have been established by the Ohio Medical Practice Act,

"THEREFORE, BE IT RESOLVED, That the Ohio State Medical Association pledges its active support to the State Medical Board in initiating a vigorous campaign to remedy this situation,

"BE IT FURTHER RESOLVED, That the Association shall request the next Ohio General Assembly to provide the State Medical Board with funds sufficient to employ additional inspectors, and

"FINALLY BE IT RESOLVED, That each County Medical Society shall be urged to lend its active support to local law enforcement agencies in the prosecution of such violators and that each society shall encourage local courts to impose sentences provided by the law on those convicted."

On **motion** by Dr. Mundy, seconded by A. R. Basinger, Stark County, and **carried**, the recom-

mendation of the committee that Substitute Resolution E be adopted was approved.

RESOLUTION F

"Resolution F, presented by William M. Skipp, Youngstown, on behalf of the Mahoning County Medical Society, read as follows:

> "BE IT RESOLVED by the Ohio State Medical Association, that
>
> "WHEREAS, for a number of years intern service in our hospitals has frequently been unsatisfactory to the patient, the hospital, and the medical staff, and
>
> "WHEREAS, Hospitals have been handicapped in enforcing their rules and regulations governing interns, due to the fact that dismissal for gross infractions of the rules was meaningless because a satisfactory completion of the internship is not a necessary prerequisite to the practice of medicine, and
>
> "WHEREAS, this condition is country wide;
>
> "NOW, THEREFORE, the Ohio State Medical Association, hereby recommends to the Ohio State Board of Medical Licensure, and the Federation of State Medical Boards of the United States, that a twelve months' internship in an accredited hospital be required of a candidate before such candidate be granted license to practice medicine and surgery;
>
> "AND FURTHERMORE, it is recommended to the Association of American Medical Colleges and to the Council on Medical Education and Licensure, that a twelve months' internship in an accredited hospital be required before a diploma of graduation from medical school be granted; and that this resolution be presented by the Ohio State Medical Association to the House of Delegates of the American Medical Association, in San Francisco, July 1-5, 1946.

"This resolution also was discussed by the committee with Dr. Upham and Dr. Platter.

"The committee recognizes the existence of the problems and complications set forth in the resolution. It realizes that there are two ways of approach to a possible solution. The first would be through the medical schools which would be requested to require a year's internship of a student before granting to him the degree of doctor of medicine. The second method suggested would necessitate amending the Medical Practice Act, so as to require internship as one of the prerequisites for obtaining a license in Ohio.

"During the deliberations of the committee, serious objections were raised to the first method outlined above. It was pointed out that should hospitals be required to employ as interns those who would not hold a license to practice medicine, hospitals would in all probability be confronted with serious legal problems and would be handicapped in their efforts to provide efficient services by members of their intern staff.

"With respect to the second method, the majority of the members of the committee were of the opinion that it would precipitate legislative difficulties and, perhaps, would create adverse public reaction.

"Therefore, your committee believes that it would be unwise for the House of Delegates to act on this matter at this time and it **recommends that the resolution not be adopted.**"

On **motion** by Dr. Mundy, seconded by M. D. Prugh, Montgomery County, and **carried, the recommendation of the committee that Resolution F be not adopted was approved.**

RESOLUTION G

"Resolution G, submitted by V. A. Killoran, Sandusky, on behalf of the Erie County Medical Society, read as follows:

> "WHEREAS, There has been a gradual increase in the number of cases of contagious disease. and
>
> "WHEREAS, There has been a gradual decrease in the immunization of children, and
>
> "WHEREAS, Local authorities often find it difficult or impossible to enforce compulsory immunization,
>
> "THEREFORE, BE IT RESOLVED, That the Erie County Medical Society recommends to the House of Delegates of the Ohio State Medical Association in convention May 7 and 8, 1946, that an effort should be made to have legislation passed making immunization compulsory for grade school entrance;
>
> "AND BE IT FURTHER RESOLVED, That the Ohio State Medical Association do not sponsor this legislation, but make an effort to have the State Department of Health or some other health-minded organization do so.

"Your committee feels that the question covered in Resolution G can be properly handled on a local level through cooperative activities and programs sponsored and supported by boards of education and local health departments, including wide-spread program of public health education. In the opinion of your committee cooperative efforts like those enumerated will provide a sounder and easier method of solving this problem than any plan based on compulsion.

"The committee, therefore, **recommends that the resolution shall not be adopted.** At the same time, the committee desires to urge that all local medical societies take the initiative in seeing that local activities such as those referred to above are inaugurated."

On **motion** by Dr. Mundy, seconded by F. N. Nagel, Lucas County, and **carried, the recommendation of the committee that Resolution G be not adopted was approved.**

RESOLUTION H

"Resolution H, submitted by Arthur J. Tronstein, Newark, on behalf of the Licking County Medical Society, read as follows:

> "WHEREAS, The proper management of cases of primary syphilis depends upon proper diagnosis of the lesion. Furthermore, early in the course of primary syphilis the

various accepted tests upon the blood are negative, therefore the proper diagnosis depends upon positive identification of the infecting spirochete by darkfield examination.

"FURTHERMORE, The proper management of any case of syphilis requires that a study of the spinal fluid be made at stated intervals during the treatment or at its supposed completion.

"THEREFORE, BE IT RESOLVED, That the Licking County Medical Society shall ask the Ohio State Medical Association to request the Department of Health of the State of Ohio to require all physicians, clinics, hospitals, etc., authorized to treat or diagnose primary syphilis to show that a proper darkfield examination was performed upon all cases and reported as being primary syphilis, and that the Department of Health shall pay the reporting individual or group a fee of five dollars ($5.00) for this service.

"FURTHERMORE, BE IT RESOLVED, That in like manner the Department of Health, in addition to the fees it now pays for the administration of anti-luetic therapy, shall pay the sum of five dollars ($5.00) for each spinal fluid study performed upon the patient whose therapy it authorizes. It shall be understood that the Department of Health may require such information as it desires concerning the spinal fluid specimen and may limit payment for such spinal fluid studies to not over three times for any one patient.

"This resolution is meritorious in that it contemplates the earlier diagnosis, and therefore, more adequate treatment of syphilis. However, your committee believes that the Ohio State Medical Association is not in a position at this time to suggest proper fees which should be paid by the State Department of Health due to the fact that the funds available to the department for venereal disease control are very limited. Also, the committee, for the purposes of clarification, suggests certain changes in the wording of the resolution as introduced.

"Therefore, the committee presents for consideration Substitute Resolution H, reading as follows, and **recommends its adoption:**

SUBSTITUTE RESOLUTION H

"WHEREAS, The proper management of syphilis depends upon accurate and early diagnosis, and

"WHEREAS, Darkfield examination, properly done, is recognized as a means of earlier diagnosis than serological examination,

"BE IT RESOLVED, That the Ohio State Medical Association recommends that the State Department of Health shall encourage the use of darkfield examination and shall not pay for treatment in those cases diagnosed as early syphilis without either darkfield or serological evidence.

"BE IT FURTHER RESOLVED, That a fee shall be paid for darkfield examination, when serology is negative, in cases within the scope of the venereal disease program of the State Department of Health."

On motion by Dr. Mundy, seconded by Arthur J. Tronstein, Licking County, and **carried, the recommendation of the committee that Substitute Resolution H be adopted was approved.**

RESOLUTION I

"Resolution I, presented by Arthur J. Tronstein, Newark, on behalf of the Licking County Medical Society, read as follows:

"WHEREAS, Each day the physician is called upon to complete numerous claim blanks for patients seeking benefits from insurance companies, lodges, fraternal funds, political subdivisions, etc., under contracts for health, accident or death benefits. And furthermore, it is seldom that the attending physician receives compensation for his time consumed in filing these numerous blanks or for his professional judgment needed in so doing;

"THEREFORE, BE IT RESOLVED, by the Licking County Medical Society, That the Ohio State Medical Association shall issue to its members, or any other licensed medical doctor in the State of Ohio, simple, but adequate, forms for filing claims for accident, health or death benefits, respectively; and that these above-named forms shall bear notice from The Ohio State Medical Society that should more than two such forms be desired for one claim, or that shall the insurer desire further information not contained in these forms, then the attending physician will comply with such requests only at the expense of the insurance company, fraternal organization, or other insurer so desiring the additional forms or information. The only exception to this procedure shall be in the filing of claims for the Industrial Commission of the State of Ohio.

"The reference committee understands that in 1942 the House of Delegates of the Ohio State Medical Association adopted a resolution quite similar to Resolution I now under consideration. The 1942 resolution subsequently was presented to the House of Delegates of the American Medical Association and was adopted by that body.

"As a result of these actions, conferences between officials of the A.M.A. and officials of various insurance companies were held. The outgrowth of these conferences was the adoption by a considerable number of insurance companies of a simplified form for medical reports.

"In view of the foregoing facts, the reference committee **recommends that the House of Delegates refer Resolution I to The Council,** requesting The Council to make an investigation of the results attained through previous actions of the official bodies of this Association and the American Medical Association and to take whatever action The Council may deem advisable."

On **motion** by Dr. Mundy, seconded by D. J.

Slosser, Defiance County, and **carried**, the recommendation of the reference committee on Resolution I **was adopted.**

RESOLUTION J

"Resolution J, presented by R. S. Binkley, Dayton, on behalf of the Montgomery County Medical Society, read as follows:

> "WHEREAS, The physicians engaged in the general practice of medicine comprise a larger numerical group than any other group of physicians in any of the specialty sections,
>
> "AND WHEREAS, There are problems peculiar to the general practice of medicine whose solution can best be accomplished by those men to whom they relate,
>
> "AND WHEREAS, Scientific programs of specific interest to those in the general practice of medicine are too seldom seen, and because this situation could best be corrected by those most concerned, the general practitioners;
>
> "THEREFORE, BE IT RESOLVED, That the delegates of the Montgomery County Medical Society to the Ohio State Convention offer and sponsor a motion for the creation of a General Practice Section of the Ohio State Medical Association.

"Your committee is in favor of the objectives enumerated in Resolution J. Because of the demand for general practitioners throughout Ohio, especially in rural areas, and because such demand far exceeds the present supply, we believe that anything which can be done to encourage men to enter general practice should have the support of this Association. Therefore, your committee **recommends the adoption of this resolution.**

On **motion** by Dr. Mundy, seconded by Emil R. Swepston, Hamilton County, and **carried**, the recommendation of the reference committee on Resolution J **was adopted.**

On **motion** by Dr. Mundy, seconded by R. D. Herlinger, Trumbull County, and **carried**, the report of the Reference Committee as a whole **was approved and adopted.**

ELECTION OF PRESIDENT-ELECT

The next order of business was the offering of nominations for the office of President-Elect.

E. O. Swartz, Cincinnati, placed in nomination the name of **R. L. Rutledge,** Alliance, serving his third term as a member of The Council representing the Sixth District. The nomination was seconded by John M. Van Dyke, Canton, and D. W. Hogue, Springfield.

There being no further nominations, on **motion** by J. A. Fraser, East Liverpool, seconded by Carl A. Lincke, Carrollton, and **carried**, the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Rutledge for the office of President-Elect.

DR. RUTLEDGE PRESENTED

Dr. Rutledge was escorted to the rostrum and introduced by Dr. Schriver. Dr. Schriver complimented Dr. Rutledge on the splendid work which he had done as a member of The Council. Dr. Rutledge replied by stating that his efforts and energies would be directed toward providing the Association with as efficient leadership as possible during his tenure of office as President starting in the Spring of 1947.

ELECTION OF COUNCILORS

The report of the Committee on Nominations was then called for. Emil R. Swepston, Cincinnati, chairman of the committee, presented the following report:

First District

The committee placed in nomination the name of **E. O. Swartz,** Cincinnati, to succeed himself as a member of The Council representing the **First District** for a term of two years. There being no further nominations, on **motion** by William M. Skipp, Youngstown, seconded by Lewis W. Cellio, Carrollton, and **carried**, the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Swartz. **This was done and Dr. Swartz was declared elected to The Council for the term 1946 and 1947.**

Third District

As Councilor for the **Third District** the committee placed in nomination the name of **J. Craig Bowman,** Upper Sandusky, to succeed Guy E. Noble, St. Marys, retiring from The Council under the constitutional provision prohibiting a member of The Council serving more than three consecutive terms. There being no further nominations, on **motion** by Carll S. Mundy, Toledo, seconded by A. R. Basinger, North Canton, and **carried**, the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Bowman. **This was done and Dr. Bowman was declared elected to The Council for the term 1946 and 1947.**

Fifth District

The committee placed in nomination the name of **Fred W. Dixon,** Cleveland, to succeed himself as a member of The Council representing the **Fifth District** for a term of two years. There being no further nominations, on **motion** by Farrell T. Gallagher, Cleveland, seconded by A. R. Basinger, North Canton, and **carried**, the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Dixon. **This was**

done and Dr. Dixon was declared elected to The Council for the term 1946 and 1947.

Seventh District

The committee placed in nomination the name of **Carl A. Lincke,** Carrollton, to succed himself as a member of The Council representing the **Seventh District** for a term of two years. There being no further nominations, on **motion** by Lewis W. Cellio, Carrollton, seconded by H. C. Messenger, Xenia, and **carried,** the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Lincke. **This was done and Dr. Lincke was declared elected to The Council for the term 1946 and 1947.**

Eighth District

Arthur J. Tronstein, Newark, was nominated by the committee to fill the unexpired term of George F. Swan, Cambridge, whose resignation as a member of The Council for the **Eighth District** was accepted by The Council on May 6. There being no further nominations, on **motion** by C. P. Swett, Lancaster, seconded by D. C. Houser, Urbana, and **carried,** the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Tronstein as a member of The Council representing the Eighth District for one year, 1946, being the unexpired term of Dr. Swan. **This was done and Dr. Tronstein was declared elected to The Council for the year 1946.**

Ninth District

As Councilor of the **Ninth District** for a term of two years, the committee placed in nomination the name of **Gilbert Micklethwaite,** Portsmouth, to succeed himself. There being no further nominations, on **motion** by H. C. Messenger, Xenia, seconded by D. A. Berndt, Portsmouth, and **carried,** the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Micklethwaite. **This was done and Dr. Micklethwaite was declared elected to The Council for the term 1946 and 1947.**

Eleventh District

The committee placed in nomination the name of **Ross M. Knoble,** Sandusky, to succeed himself as a member of The Council representing the **Eleventh District** for a term of two years. There being no further nominations, on **motion** by V. A. Killoran, Sandusky, seconded by Charles R. Meek, Lorain, and **carried,** the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Knoble. **This was done and Dr. Knoble was declared elected to The Council for the term 1946 and 1947.**

ELECTION OF TREASURER

For the office of **Treasurer** for a three-year term—1946, 1947, and 1948—the committee placed in nomination the name of **H. P. Worstell,** Columbus. There being no further nominations, on **motion** by R. C. Young, Toledo, seconded by E. P. McNamee, Cleveland, and **carried,** the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Worstell to succeed John H. Mitchell, Columbus, who had expressed a desire to retire from that office. **This was done and Dr. Worstell was declared elected to the office of Treasurer for a three-year term—1946, 1947, and 1948.**

ELECTION OF DELEGATES AND ALTERNATES TO A.M.A.

The committee then presented nominations for the offices of Delegate and Alternate to the American Medical Association. The following were nominated as Delegate and Alternate, respectively, for a **term of one year—1946:**

Delegate: Barney J. Hein, Toledo
Alternate: Frank M. Wiseley, Findlay

Delegate: William M. Skipp, Youngstown
Alternate: Russel G. Means, Columbus

Delegate: L. Howard Schriver, Cincinnati
Alternate: E. O. Swartz, Cincinnati

Delegate: C. C. Sherburne, Columbus
Alternate: George T. Harding, Columbus

There being no further nominations, on **motion** by F. N. Nagel, Toledo, seconded by E. J. Wenaas, Youngstown, and **carried,** the nominations for the above positions were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for these physicians as Delegates and Alternates, respectively, to the American Medical Association. **This was done and the above were declared duly elected for a term of one year—1946.**

As Delegates and Alternates, respectively, to the American Medical Association for a **term of two years**—1946 and 1947—the committee placed in nomination the following:

Delegate: E. P. McNamee, Cleveland
Alternate: Herbert B. Wright, Cleveland

Delegate: Carl R. Steinke, Akron
Alternate: D. J. Slosser, Defiance

Delegate: George A. Woodhouse, Pleasant Hill
Alternate: Roy S. Binkley, Dayton

Delegate: Carl A. Lincke, Carrollton
Alternate: H. M. Platter, Columbus

There being no further nominations, on **motion** by Fred W. Dixon, Cleveland, seconded by Lewis W. Cellio, Carrollton, and **carried,** the nominations for the above positions were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for these physicians as Delegates and Alternates, respectively, to the American Medical Association. **This was**

done and the above were declared duly elected for a term of two years—1946 and 1947.

NEW SIXTH DISTRICT COUNCILOR ELECTED

At this point R. L. Rutledge, Alliance, previously elected President-Elect, tendered his resignation as a member of The Council representing the Sixth District in order to give the House of Delegates an opportunity to select his successor. On **motion** by Gilbert Micklethwaite, Portsmouth, seconded by R. C. Hunter, Wapakoneta, and **carried**, Dr. Rutledge's resignation **was accepted.**

President Schriver declared the office of Councilor of the Sixth District vacant and asked for nominations to fill such vacancy.

R. E. Pinkerton, Akron, placed in nomination the name of **Paul A. Davis**, Akron, as a member of The Council for the **Sixth District** to fill the unexpired term of Dr. Rutledge ending in the Spring of 1947. There being no further nominations, on **motion** by A. R. Basinger, North Canton, seconded by William M. Skipp, Youngstown, and **carried**, the nominations were closed and the Secretary was instructed to cast the unanimous ballot of the House of Delegates for Dr. Davis to succeed Dr. Rutledge on The Council for one year—1946. **This was done and Dr. Davis was declared elected to The Council for the year 1946.**

President Schriver then called to the rostrum those who had been elected or re-elected to offices of the Association and installed them, at the same time presenting to E. P. McNamee, Cleveland, the incoming President, the official gavel of the Association.



E. P. McNAMEE, M.D.

Dr. McNamee then took the chair and made a brief talk, complimenting Dr. Schriver, the retiring President, and C. C. Sherburne, Columbus, the immediate Past-President, and at the same time requesting the cooperation and active help of the members of the House of Delegates and all members of the Association during his tenure of office.

COMMITTEES APPOINTED

At this point Dr. McNamee presented the following appointments to the standing committees of the Association and asked for confirmation of the House of Delegates:

Committee on Public Relations and Economics—Horace B. Davidson, Columbus, to serve as a member of the committee for a term of five years, 1946-1951, inclusive. **James G. Kramer**, Akron, to serve as a member of the committee for a term of four years, 1946-1950, inclusive. **Barney J. Hein**, Toledo, now a member of the committee, to serve as chairman for the ensuing year.

Committee on Education—J. Edwin Purdy, Canton, to serve as a member of the committee for a term of five years, 1946-1951, inclusive. **J. L. Webb**, Nelsonville, to serve as a member of the committee for a term of four years, 1946-1950, inclusive. **Carl A. Wilzbach**, Cincinnati, now a member of the committee, to serve as chairman for the ensuing year.

Judicial and Professional Relations Committee—E. J. Wenaas, Youngstown, to serve as a member of the committee for a term of five years, 1946-1951, inclusive. **S. A. Hatfield**, Columbus, to serve as a member of the committee for a term of four years, 1946-1950, inclusive. **John A. Caldwell**, Cincinnati, now a member of the committee, to serve as chairman for the ensuing year.

Committee on Scientific Work—Martin W. Diethelm, Toledo, to serve as a member of the committee for a term of five years, 1946-1951, inclusive. **Charles A. Doan**, Columbus, to serve as a member of the committee for a term of four years, 1946-1950, inclusive. **Louis G. Herrmann**, now a member of the committee, to serve as chairman for the ensuing year.

On **motion** by Gilbert Micklethwaite, Portsmouth, seconded by H. C. Messenger, Xenia, and **carried**, the foregoing appointments of the President **were officially confirmed** by the House of Delegates.

President McNamee then called for the presentation of new or unfinished business.

Carll S. Mundy, Toledo, **moved** that the House of Delegates express sincere appreciation and thanks to the Committee on Scientific Work, the Columbus committees on arrangements, the Headquarters Staff of the State Association, the managements of the Neil House and Deshler-Wallick Hotel, the Columbus newspapers, and all others concerned for their part in making the Centennial Anniversary Meeting a success. The motion was seconded by numerous delegates and **adopted** by a unanimous vote.

There being no further business, the House of Delegates adjourned sine die.

Attest CHARLES S. NELSON,
Executive Secretary.

House of Delegates Roll Call
Centennial Anniversary Meeting

County	Delegate	First Session	Second Session
Adams	S. J. Ellison	present	present
Allen	J. R. Johnson	present	present
Ashland	George M. Emery	present	present
Ashtabula	R. B. Wynkoop	.....	.....
Athens	H. H. Fockler	present	.....
Auglaize	R. C. Hunter	present	present

County	Delegate	First Session	Second Session
Belmont	J. B. Martin	present	present
Brown	R. B. Hannah	----------	----------
Butler	Chas. T. Atkinson	present	present
Carroll	Lewis W. Cellio	present	present
Champaign	D. C. Houser	present	present
Clark	D. W. Hogue	present	present
Clermont	Pearl Zeek-Minning	----------	----------
Clinton	Robert Conard	present	present
Columbiana	J. A. Fraser	present	present
Coshocton	G. A. Foster	----------	----------
Crawford	D. G. Arnold	present	present
Cuyahoga	Farrell T. Gallagher	present	present
"	J. T. Ledman	present	present
"	R. B. Crawford	present	present
"	Robert F. Parker	present	present
"	A. B. Bruner	present	present
"	M. Paul Motto	present	present
"	James N. Wychgel	present	present
"	D. M. Keating	present	present
"	C. G. LaRocco	present	present
"	Fay A. LeFevre	present	present
"	John H. Budd	present	present
"	James E. Hallisy	present	present
"	J. W. Conwell	present	present
"	C. A. Swan	present	present
"	R. J. Whitacre	present	----------
"	J. H. Lazzari	present	present
Darke	J. E. Gillette	present	present
Defiance	D. J. Slosser	present	present
Delaware	M. W. Livingston	----------	----------
Erie	V. A. Killoran	present	present
Fairfield	C. P. Swett	present	present
Fayette	J. H. Persinger	present	present
Franklin	James A. Beer	present	present
"	I. B. Harris	present	present
"	Charles W. Pavey	present	----------
"	F. C. Hugenberger	present	present
"	Drew L. Davies	present	present
"	George J. Heer	present	present
"	W. L. Pritchard	present	present
Fulton	L. C. Cosgrove, Sr.	present	present
Gallia	F. W. Shane	----------	----------
Geauga	H. E. Shafer	present	----------
Greene	C. G. McPherson	----------	present
Guernsey	Earl E. Conaway	present	----------
"	J. A. L. Toland	----------	present
Hamilton	E. A. Kindel	present	present
"	A. Clyde Ross	present	----------
"	H. H. Shook	----------	present
"	Joseph Bolin	present	present
"	Harold F. Downing	present	present
"	Louis J. Hendricks	present	present
"	Donald J. Lyle	----------	present
"	Harry L. Fry	present	----------
"	William J. Graf	----------	present
"	D. W. Heusinkveld	present	present
"	Emil R. Swepston	present	present
Hancock	Frank M. Wiseley	present	----------
Hardin	H. A. Kerns	present	present
Harrison	Carl F. Goll	present	present
Henry	J. R. Bolles	----------	----------
Highland	H. H. Lowe	----------	present
Hocking	C. T. Grattidge	present	present
Holmes	A. T. Cole	present	present
Huron	H. C. Sparks	----------	----------
Jackson	Marlin R. Wedemeyer	----------	----------
Jefferson	John F. Gallagher	present	----------
Knox	Geo. B. Imhoff	----------	----------
Lake	M. G. Carmody	present	present
Lawrence	George G. Hunter	----------	present
Licking	Arthur J. Tronstein	present	present
Logan	Charles L. Barrett	present	present
Lorain	Charles R. Meek	present	present
"	S. V. Burley	present	present
Lucas	F. N. Nagel	present	present
"	R. C. Young	present	present
"	M. R. Lorenzen	present	present
"	Carll S. Mundy	present	present
Madison	J. W. Hurt	----------	----------
Mahoning	E. J. Wenaas	present	present
"	John N. McCann	present	present
"	Wm. M. Skipp	present	present
Marion	J. A. McNamara	present	present
Medina	N. J. M. Klotz	----------	present
Meigs	R. E. Boice	present	present
Mercer	Rudolph Schmidt	present	----------
Miami	J. E. Bausman	present	present
Montgomery	R. S. Binkley	present	present
"	M. R. Haley	present	present
"	M. D. Prugh	present	present
"	Ned D. Shepard	present	present
Morgan	C. E. Northrup	----------	present
Morrow	J. P. Ingmire	present	present
Muskingum	M. A. Loebell	present	present
Noble	----------	----------	----------
Ottawa	George A. Boon	present	present
Paulding	D. E. Farling	present	----------
Perry	James Miller	----------	present
Pickaway	E. S. Shane	present	present
Pike	Robert T. Leever	----------	present
Portage	Myron S. Owen	----------	----------
Preble	Carle W. Beane	----------	present
Putnam	H. N. Trumbull	----------	----------
Richland	John S. Hattery	----------	present
Ross	Ralph W. Holmes	present	present
Sandusky	J. L. Curtin	present	present
Scioto	D. A. Berndt	----------	present
Seneca	R. F. Machamer	present	present
Shelby	H. C. Clayton	----------	present
Stark	A. R. Basinger	present	present
"	John M. Van Dyke	present	present
"	R. H. Clunk	----------	present
Summit	W. A. Keitzer	present	present
"	Kurt B. Weidenthal	present	present
"	V. C. Malloy	present	present
"	R. E. Pinkerton	present	present
Trumbull	R. D. Herlinger	present	present
Tuscarawas	Jay W. Calhoon	----------	present
Union	Evert J. Marsh	present	present
Van Wert	J. R. Jarvis	present	present
Vinton	H. D. Chamberlain	----------	----------
Warren	Robert M. Wilson	present	present
Washington	W. E. Radcliff	present	present
Wayne	F. C. Ganyard	present	present
Williams	H. W. Wertz	present	present
Wood	Earl D. Foltz	present	present
Wyandot	J. Craig Bowman	present	present
	OFFICERS		
President	L. Howard Schriver	present	present
President-Elect	Edgar P. McNamee	present	present
Past-President	C. C. Sherburne	present	present
Treasurer	John H. Mitchell	----------	----------
	COUNCILORS		
First District	E. O. Swartz	present	present
Second District	H. C. Messenger	present	present
Third District	Guy E. Noble	present	present
Fourth District	A. A. Brindley	present	----------
Fifth District	Fred W. Dixon	present	present
Sixth District	R. L. Rutledge	present	present
Seventh District	Carl A. Lincke	present	present
Eighth District	George F. Swan	present	----------
Ninth District	Gilbert Micklethwaite	present	present
Tenth District	H. M. Clodfelter	present	present
Eleventh District	Ross M. Knoble	present	present
TOTALS		115	119

Mrs. George A. Woodhouse Dies

The many friends of Dr. George A. Woodhouse, Pleasant Hill, will regret to learn of the death on May 5 of his wife, Mrs. Dorothy Woodhouse, aged 46, following a cerebral hemorrhage. Survivors include a daughter, Mrs. Marie A. Jackson, of the nursing staff of Miami Valley Hospital, Dayton; three sons, George, recently returned from duty in the South Pacific; John, in service in Belgium; and Dean, at home. Also surviving are seven sisters. Dr. Woodhouse is a member of the Judicial and Professional Relations Committee, the Committee on Legislation, a delegate to the American Medical Association, and secretary of the Miami County Medical Society. Mrs. Woodhouse was in effect ex-officio secretary of the county society, having helped in getting out bulletins and in other responsibilities of that office.

Annual Address of the President

By L. HOWARD SCHRIVER, M.D., Cincinnati, Ohio

THIS annual meeting in the year 1946 brings to a close 100 continuous years of service by the Ohio State Medical Association to the people and medical profession of Ohio. A scrutiny of this record of service reveals accomplishments of which the members of this Association may well be proud.

During the past 100 years, rapid and great changes have occurred. Ohio has grown from a sparsely inhabited agricultural community, containing few urban areas, to an industrial-agricultural empire, thickly populated and containing many metropolitan regions.



L. H. SCHRIVER, M.D.

Also, within the 100 years' history of the Ohio State Medical Association, scientific knowledge which has produced revolutionary changes in the social and economic life of the community has been developed and applied. The medical profession has been dynamic in the creation and application of scientific knowledge. Its record compares favorably to that of any field of scientific endeavor.

Yet, we must remember that the above facts have been responsible for the development of a complex organization of society, making it necessary for each important segment of society to accept increasing functions and responsibilities.

CONDITIONS HAVE CHANGED

One hundred years ago the functions and responsibilities of the medical profession were on an individual basis for the most part. Today, medical functions and responsibilities are on a group basis as well as on an individual basis.

Whereas a century ago the total responsibility of the medical profession consisted of therapeutic administrations to the ill person, today the functions of the medical profession include not only administration to the sick individual but responsibility for the well being of groups of individuals, namely that which we know as public health or preventive services.

Because of this change, it has been necessary for the medical profession to cooperate with many groups and agencies, both private and governmental in character, which are interested in the health of the people. The medical profession has accepted this responsibility wholeheartedly without thought of gain for itself. This giving of cooperative effort and counsel to any and all groups interested in health has been accepted by the profession as an obligation to the public—a duty.

In its official deliberations and in formulating its policies, the medical profession always has considered the welfare of the public of supreme importance. Never has the profession permitted the material welfare of the profession to compromise its decisions on matters of public policy; never has it attempted to regulate the distribution of its services to the community or to the individual. Medical services always have been available to the people, poor or rich, throughout widely variable economic periods of American history. These facts are challenges to any group which distributes vital services or commodities to the people of the United States.

MEDICINE'S GREAT RECORD

In the past 100 years, the scientific and therapeutic accomplishments of medicine speak for themselves. Nevertheless, a few should be mentioned.

The span of life itself has been prolonged many years, especially during the last half of this 100-year period, namely, from an average of 37 years to that of 65 years.

Many diseases which were the scourges of mankind, such as smallpox and cholera, have practically disappeared in many parts of the country. Other diseases such as diphtheria, typhoid fever, tetanus, typhus fever, yellow fever, whooping cough, scarlet fever, etc., can be, and are being, controlled. They can be eliminated entirely if the medical knowledge which is within the reach of all is accepted and utilized.

Despite existent unfavorable conditions, great progress has been made in the reduction of the incidence of tuberculosis. Statistics show approximately 50 per cent reduction in the death rate from tuberculosis during the past 25 years as a result of early diagnosis and improved therapy.

In surgery the progress has been revolutionary. Pathological conditions arising in any of the three great cavities of the body which were not in any way amenable to treatment as rendered a century ago are today treated by methods

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Annual Address of the President, delivered at the first session of the House of Delegates, Ohio State Medical Association, at the Centennial Anniversary Meeting, Columbus, Ohio, May 7, 1946.

which are considered commonplace procedures of modern therapy.

The glorious accomplishments of the medical profession by the application of preventive and curative measures in the armed forces of the United States in World War II constitute a record of service unequalled in history. We are proud of that record not only because of the accomplishments but also because of the heroism displayed and the sacrifices made by the medical personnel of the armed forces. On behalf of the Ohio State Medical Association I welcome our service men back to their homes and loved ones. Our hope for them is a normal, happy, useful life.

The application and utilization of scientific knowledge have raised the American standard of living beyond the imagination of the most optimistic minds of 100 years ago. They have made the "abundant" life possible.

UNCERTAINTY AND CONFUSION

Nevertheless, there is much to be desired. Uncertainty, confusion, and unhappiness prevail. To the returned service man the impact of this realization is no doubt overwhelming. To those of us who remained at home during the war years this is disconcerting, to say the least.

We find ourselves living in a state of confusion which is the greatest ever experienced within the recollection of man. Great changes have occurred, affecting the life, customs, and behavior of our people, individually and collectively. Individual freedom has been curtailed. Efforts have been made to sabotage democracy. Government by law has been replaced by government based on opinions rendered by a bureaucracy from which there is no appeal.

In the past it has been customary to encourage and to expend every effort to produce an economy of plenty. Today, and for the past few years, concentrated and organized efforts have been utilized to create an economy of scarcity. Suppressive controls are exercised to discourage ingenuity and creative efforts in industry and agriculture. Encouragement of individual effort has been replaced by regimentation and standardization. The result has been the encouragement and development of mediocrity.

IRRESPONSIBLE LEADERS

For a century or more in America, the workers of the nation have been banded together into organizations; the objectives of which have been to bring about the social and economic advancement of working men and women. For many years these organizations were conducted according to the best judgments of free men. Many obstacles and hardships were placed in their paths; many were overcome. Their history is not one free of mistakes, yet progress was made toward the improvement of the social, economic, and working conditions of their members—more progress than in any other period in the history of man.

However, within recent years, with the assistance and encouragement of many high government officials, the members of these organizations have yielded democratic control of their own organizations to a few power-seeking leaders who have used their constituency as pawns to gather more and more power and authority for themselves. Freedom, the greatest heritage of the rank and file, has been surrendered for a false security.

We find these same leaders resisting in every possible way curtailment of their acts and power; refusing to accept responsibility for the protection of the interests of the public as a whole. We have witnessed the denial, by mob violence, of the right of the individual to work for whom and when he pleases. We have witnessed the forceful prevention of ingress and egress of owners of property and businesses. Governmental authority has failed to protect these citizens and their constitutional guarantees. Democracy and freedom under a rule of law have made our country productive and powerful, and its civilization the best. None of these can survive under a regime of anarchy.

Now, we find these same leaders spearheading efforts to take from the medical profession its democratic freedom and to replace it with regimentation and bureaucratic control, regardless of the effect this would have on the health of the American people.

DEMOCRACY THREATENED

American civilization was in a great part built upon the compassion of the American people, the desire to help one's friends and neighbors; voluntary help—the characteristic of a compassionate people. Because of faulty leadership, we as a people have become materialistic, arrogant, intolerant, bigoted, and in many of our actions, ruthless. Duplicity and trickery have too often been substituted for honesty and frankness. This is a natural sequence to the abandonment of normal democratic processes; to concentration of power and authority in a small group of individuals—some within government, some outside of government.

Powerful groups and influential individuals still exert themselves, tirelessly and continuously, to extend and make complete, totalitarian government in the United States. This seems preposterous in a nation where the highest standard of living ever developed has been brought about through individual freedom, democratic processes, decentralization of authority. Yet, it is true.

During the period of our country's greatest development, medical services have been of the highest quality and distribution of these services more far-reaching than in any community of the world. This is true by any and all means of com-

parison. Yet, one of the first social-economic groups as an entity to be attacked, maligned, and blasphemed by the advocates of centralization of authority under political control was the medical profession.

GOVERNMENT CONTROL FATAL

In my opinion, a civilization which even tolerates consideration of political control of the practice of medicine is a civilization which needs reorientation or is doomed to destruction. The history of governmental control of the practice of medicine is rife with scandal, inefficiency, dishonesty, favoritism of the politically powerful, and medical care of mediocre quality.

The record of the Veterans Administration during its first 25 years is confirmation of this charge. It was this fact that prompted Maj. Gen. Paul Hawley, now medical director of the Veterans Administration, to say: "Until the medical care of the veteran is taken over and directed by private practicing physicians and specialists, it will be unsatisfactory".

Advocates of governmental control of the practice of medicine frequently refer to the record of the medical corps during World War II. True, the medical corps had a record of which the nation is proud. However, that record was made primarily through the accomplishments of the reserve officers—those who left their private practices when the nation needed their services—in spite of the inefficiencies, red tape, and policy of misplacement and waste of medical manpower of the regular services.

Moreover, this accomplishment, in no small measure, was due to the exceptional education and training which students of medicine have received during the past 25 or more years. Let us not forget that this was possible because medical education has been comparatively free from political domination and bureaucratic manipulations.

THREAT TO EDUCATION

The dangers of the invasion of government into the field of medical education on a wholesale scale are appearing upon the horizon. True, medical education of necessity is expensive. Nevertheless, to cheapen it through political interferences and governmental dictation would cause a disaster of the first magnitude. To prevent this from happening, as private citizens, interested in and desirous of the continuation of progress in medical education, we must give material aid and assistance to our institutions of medical training. Above all we must fight to maintain for them their academic freedom.

There is much the medical profession can do to prevent the passage of proposed legislation, such as the Wagner-Murray-Dingell Bills. The people of our country must be warned of the destructive effects of such measures on medical services generally. We owe this to the public. The public is interested and wants information.

It is the responsibility of each physician to carry out this assignment. Will we as a profession accept this responsibility? Too often I have observed physicians who have been asked by groups to meet with them for discussion of this and other questions, beg off or try to get someone else to fill the engagement. Your president has accepted many such invitations. He wishes he had the time and energy to accept more. This is not meant as a boast for I always have felt that asking me or any physician to render this kind of a public service is not asking too much, especially when the job may be a real contribution toward the preservation of the dignity and high standards of medicine—and human freedom.

PUBLIC RELATIONS ESSENTIAL

There is much which medical organization can do toward improvement of its public relations. The Ohio State Medical Association has accepted its responsibility in this activity. Our Department of Public Relations which had to be curtailed during the war, has been re-established and its activity will be rapidly increased during the coming months.

The Ohio State Medical Association has met its responsibility in the nation-wide effort being made to provide all with an opportunity to participate in voluntary prepaid medical care programs. It has created Ohio Medical Indemnity, Inc., which has been functioning since January of this year and which to date has 8,000 contracts in force, covering 20,000 persons. Twenty-three state medical societies have similar plans in operation and the American Medical Association has developed a national coordinating agency for all state plans. It is anticipated that in the near future each state will have one or more prepayment plans, sponsored by the medical profession, in effect.

These activities are an answer to the advocates of government-controlled medical care programs. Through these programs, medical care will retain its superlative character in contrast to the mediocrity, inefficiency, dishonesty, red tape, neglect, and excessive costs which always have been characteristic of politically-controlled plans.

Even should the medical profession continue its functions and carry on a program such as I have outlined briefly, the outcome of the present struggle may not be as we would desire. Under such conditions I believe members of the medical profession can be masters of their destiny. What I propose, I do after serious and long consideration.

CHALLENGE ISSUED

If I may reiterate: I have no doubt that the democracy of the United States of America and the individual freedom of its people are dependent upon the final action taken by the Con-

gress on the Wagner-Murray-Dingell Bills. Believing this to be true, I, personally, would feel that I would be a traitor to human progress if I were to participate in the practice of medicine under the provisions of such a law. Therefore, I would refuse to participate. If patients desired my services and if the coercive authority of this legislation permitted me to render service without participating in the government program, I would render services. Personally, I will never be guilty of prostituting the highest ethical and greatest service profession to political despoiliation. I would rather be a pauper with freedom and dignity than a serf with security.

In conclusion, I wish to make two specific recommendations:

1. Because I am of the opinion that the present Emergency Maternity and Infant Care program of the Federal Government has ceased to be—if it ever was—a needed governmental activity; and because it is not in harmony with the principles of the practice of medicine by free men; and because it is a fore-runner of the proposed Pepper plan for governmental medical care for all mothers and all children up to 21 years of age—a plan which would federalize all mothers and children in America—I recommend that this House of Delegates demand discontinuance of the E.M.I.C. program.

2. After years of continuous service on The Council of The Ohio State Medical Association and observation of the constantly increasing functions of the Association, I am convinced that an increase in the operating funds of the Association is necessary, so its officers, Councilors, committees, and employees can render improved services—services which may be vital to our freedom. I recommend an increase in the annual per capita dues from $7.00 to $15.00, effective January 1, 1947.

COOPERATION APPRECIATED

As I retire as your president, I would be seriously remiss if I did not express to the members of the Ohio State Medical Association appreciation of the honor you bestowed upon me two years ago. It had not been my good fortune previously to receive any honor comparable to this and my appreciation of it is great. It has been a double term of office due to the war. Much has happened and much work has been accomplished.

For the latter I want to thank The Council and the various committeemen for their untiring efforts and assistance, and their many kindnesses to me. To the women employed in our Columbus office, I extend sincere thanks and gratefully acknowledge their fine cooperation and faithful services. To Mr. Page, the newest of our full-time staff, I wish every success and happiness in his work with the Association. To Mr. Nelson and to Mr. Saville I owe the deepest gratitude for their understanding, patience, guidance, and faithful and efficient services. Without them that which has been accomplished during the past two years would have been impossible.

Being President of the Ohio State Medical Association has been a grand experience, a great honor, and I thank you most sincerely.

Interesting Program Presented at Student Health Association Meeting

The twenty-second annual meeting of the Ohio Student Health Association was held April 5 and 6 at the Deshler-Wallick Hotel in Columbus.

The meeting was opened by an address of the president, Dr. John W. Wilce, director of the student health service of the Ohio State University. Dr. Wilce spoke on "Widening Medical Horizons". His talk was followed by a symposium on "Malaria and the Veteran in College". Those participating were Dr. E. Herndon Hudson, director of the student health service, Ohio University, and Dr. M. F. Osborn, Dr. Benjamin Houghton, and Dr. James A. Beer, all of Ohio State University.

A symposium on "Orthopedic Problems and Physical Rehabilitation of Student Veterans", was next on the program with Dr. H. P. Worstell, Dr. Shelby Gamble, and Arthur Daniels Ed. D., all connected with Ohio State University, serving on the panel.

Dr. Nicholas Michael of the Ohio State University discussed the "Problem of the Student Epileptic", and Dr. Ruth St. John, of the same institution, spoke on "Aspects of Female Endocrinology" after the symposia, and sound movies and the Ohio College Association dinner climaxed the first day's program.

The program continued on April 6, with a business meeting, and later an address by Dr. Roger Heering, State Director of Health, on cooperation between the State Health Department and college health services.

Another symposium, "The Mental Health of the Veteran", included discussions by Dr. T. C. Allenbach, Ohio State University; Dr. Michael, and Dr. Edward O. Harper of Western Reserve University, Cleveland. After a round table discussion on current administrative and clinical problems, the annual luncheon was held at the Deshler-Wallick Hotel, addressed by Dr. Charles A. Doan, dean of the Ohio State University College of Medicine, on the subject "The Interpretation of Calcified Pulmonary Nodules in Ohio—Acid Fast vs. Histoplasmosis Infections".

Sandusky—Dr. Ross Knoble spoke on "Socialized Medicine" at a meeting of the Exchange Club, April 23, in the Hotel Rieger. Dr. Knoble is Eleventh District Councilor of the Ohio State Medical Association.

Views Snapped at Centennial Anniversary Banquet



SPEAKERS' TABLE

Top Row—Dr. Robert Carothers, Dr. Charles Lukens, Mrs. Lukens, Dr. J. H. J. Upham, Mrs. John H. Mitchell, Dr. Mitchell, Mrs. R. L. Rutledge, Dr. Rutledge, Mrs. L. Howard Schriver, Dr. Schriver, Philip D. Jordan, Ph.D., Dr. Edgar P. McNamee, Mrs. McNamee, Dr. C. C. Sherburne, Mrs. Sherburne, Dr. R. S. Fidler, Mrs. Fidler, Dr. William E. Lower, Mrs. Lelah Houser Furrow, Dr. D. C. Houser, Dr. John A. Caldwell.
Center Row—Dr. Paul A. Davis, Dr. Roy McClure, Mrs. Davis, Dr. E. J. McCormick, Katherine Anne Cummer, Dr. Clyde L. Cummer, Mrs. Cummer, Dr. H. M. Platter, Mrs. John B. Alcorn, Mrs. Barney J. Hein, Dr. Hein, Mrs. Harry V. Paryzek, Dr. Paryzek, Mrs. Wm. M. Skipp, Dr. Skipp, Mrs. E. O. Swartz, Dr. Swartz, Mrs. Guy E. Noble, Dr. Noble.
Lower Row—Dr. J. Craig Bowman, Mrs. Bowman, Dr. H. C. Messenger, Dr. Ross M. Knoble, Mrs. Knoble, Dr. Carl A. Lincke, Mrs. Lincke, Dr. A. A. Brindley, Dr. Fred L. Dixon, Dr. Arthur J. Tronstein, Mrs. Gilbert Micklethwaite, Dr. Micklethwaite, Mrs. H. M. Clodfelter, Dr. Clodfelter, Mrs. H. P. Worstell, Dr. Worstell, Alice Ann Forman, Dr. Jonathan Forman.



Introducing:

The New Officers and Members of The Council Elected At Recent Annual Meeting of State Association

FOLLOWING are biographical sketches of the new President-elect, new Treasurer, and three new members of The Council, elected by the House of Delegates of the Ohio State Medical Association at the Centennial Anniversary Meeting held in Columbus, May 7, 8, and 9. Their pictures appear on the cover page of this issue.

THE PRESIDENT-ELECT

Dr. Ralph L. Rutledge, Sr., Alliance, unanimous choice of the House of Delegates for the office of President-elect of the Ohio State Medical Association, has been Sixth District Councilor for the Association since 1939.

Dr. Rutledge was born in Augusta, Ohio, September 15, 1892. Following his graduation from the McKeesport, Pa., High School, he entered the University of Pittsburgh where he obtained his bachelor of science degree in 1914, and doctor of medicine degree in 1916.

After an internship in Allegheny General Hospital, Pittsburgh, he enlisted in the orthopedic branch of the Army Medical Corps and after active service in France during World War I, was honorably discharged in June, 1919, with the rank of captain.

Dr. Rutledge is specializing in orthopedic surgery, having taken postgraduate work at Harvard Medical School, the New York Orthopedic Hospital, and the New York Postgraduate Medical School.

Located in Alliance since July, 1919, Dr. Rutledge is a Fellow of the American Medical Association; past-president of the Stark County Medical Society; past-president of the Alliance City Hospital Staff; past-president of the Alliance Rotary Club; member of various Masonic orders; member of the Presbyterian Church, Phi Rho Sigma Fraternity, American Legion, and the Alliance Chamber of Commerce.

Dr. Rutledge is married and has two children, Ralph, Jr., a junior at Harvard Medical School, and Nancy Anne, a student at Alliance High School.

THE TREASURER

The new treasurer of the Ohio State Medical Association is Dr. H. P. Worstell, Columbus, also an orthopedic surgeon.

Dr. Worstell was born in Knoxville, Iowa, August 9, 1899. He was graduated from Knoxville High School in 1920, and attended Coe College, Cedar Rapids, Iowa, from 1920-1922, and the University of Iowa 1922-1928, where he received his bachelor of science and doctor of medicine degrees. He was an intern at Toledo Hospital, 1928-1929, and resident at Mercy Hospital, Toledo, 1929-1930.

He took postgraduate work in orthopedic surgery at the State University of Iowa, Iowa City, from 1930-1933 and was engaged in private practice in Columbus from 1933 to 1941. He served as orthopedic consultant to the Ohio Industrial Commission, assistant supervisor, and supervisor, of the medical section from 1931 to 1941.

Dr. Worstell was in the Navy during both world wars. In World War II he served from December, 1941, to February, 1946, and was separated from service with the rank of captain in the Navy Medical Corps,

Dr. Worstell is on the staff of University, St. Francis, Grant, and Children's Hospital in Columbus; a consultant in student health at the Ohio State University; an instructor in the University's College of Medicine; a Fellow of the American Medical Association and the Academy of Orthopedic Surgeons. He was certified by the American Board of Orthopedic Surgery in 1937. He is a member of the Tau Kappa Epsilon and Phi Beta Pi fraternities, the Masonic Lodge, and the Presbyterian Church. Dr. Worstell is married and has four children.

THIRD DISTRICT COUNCILOR

Newly elected Councilor for the Third District is Dr. J. Craig Bowman of Upper Sandusky.

Dr. Bowman is 58 years of age and is a graduate of the University of Chicago and Rush Medical College.

He interned at Presbyterian Hospital, Chicago, and Grant Hospital, Columbus. In World War I he served as an officer in the Army Medical Corps and now holds the rank of major (inactive).

Dr. Bowman has been a member of the House of Delegates of the Ohio State Medical Association for approximately 30 years continuously. Also he has served on the Committee on Medical Economics and Committee on Workmen's Compensation of the State Association. In 1944 he was chairman of the General Practitioners' Section of the American Medical Association. He is secretary and past-president of the Wyandot County Medical Society.

Dr. Bowman is married and has two children, a son who is a junior in Kenyon College, and a daughter, a junior at Ohio Wesleyan University.

SIXTH DISTRICT COUNCILOR

Dr. Paul A. Davis, Akron, is the new Councilor for the Sixth District. Dr. Davis, who was born in 1889, was graduated from the Ohio State University in 1916 with A. B., M. A., and M. D. degrees.

He is president-elect of the Summit County Medical Society; Fellow of the American Medical Association; Fellow, American Association of Industrial Physicians and Surgeons; and chairman of the scientific exhibit, section on preventive medicine of the American Medical Association.

Dr. Davis is president of the Physicians' Club of Summit County and a Fellow of the American Public Health Association. Mrs. Davis is the 1946 President of the Woman's Auxiliary to the Ohio State Medical Association.

EIGHTH DISTRICT COUNCILOR

The new Eighth District Councilor, Dr. Arthur J. Tronstein, Newark, was born in Cleveland, December 16, 1906. He received his bachelor of arts degree from Western Reserve University in 1929 and his medical degree from the Ohio State University in 1935.

He interned at Mt. Sinai Hospital in Cleveland for a year, then opened private practice in Newark, Ohio, August, 1936.

Dr. Tronstein is past-president of Chi Chapter of Phi Delta Epsilon Fraternity; member of the staff of Newark Hospital as well as consultant in dermatology and syphilology and instructor in materia medica for the Nursing School of that institution.

He has been affiliated for five years with the department of dermatology at the Ohio State University College of Medicine, and is a former vice-president of the Licking County Medical Society. He is married and has two children.

COMING MEETINGS

American Medical Association, San Francisco, July 1-5.

American Academy of Tuberculosis Physicians, San Francisco, June 30.

American Association for the Surgery of Trauma, San Antonio, Texas, June 26-28.

American Association of Plastic Surgeons, Toronto, Canada, June 3-4.

American Association for the Study of Goiter, Chicago, June 20-22.

American Association of Genito-Urinary Surgeons, Stockbridge, Mass., June 20-22.

American College of Allergists, San Francisco, June 28-30.

American College of Radiology, San Francisco, June 29.

American College of Chest Physicians, San Francisco, June 27-30.

American College of Surgeons, New York City, Sept. 9-13.

American Congress of Physical Medicine, New York City, Sept. 4-7.

American Dermatological Association, Hot Springs, Va., June 10-14.

American Dietetic Association, Cincinnati, Oct. 14-18.

American Medical Women's Association, San Francisco, June 29-30.

American Neurological Association, San Francisco, June 26-28.

American Ophthalmological Society, San Francisco, June 26-28.

American Orthopedic Association, Hot Springs, Va., June 27-29.

American Proctological Society, San Francisco, June 30.

American Radium Society, San Francisco, June 28-29.

American Society of Clinical Pathologists, San Francisco, June 27-30.

Association for the Study of Internal Secretions, San Francisco, June 28-29.

National Tuberculosis Association, Buffalo, N.Y., June 11-13.

American Public Health Association, Cleveland, week of Nov. 11.

American Roentgen Ray Society, Cincinnati, Sept. 17-20.

American Urological Association, Cincinnati, July 22-25.

Interstate Postgraduate Medical Association, Cleveland, Oct. 15-18.

National Gastro-Enterological Association, New York City, June 19-21.

Washington C. H.—Dr. Brent A. Welch, Sidney, has been employed as health commissioner of Fayette County at a salary of $5,000 per year. Dr. Welch served for 56 months in the U. S. Army Medical Corps.

Proceedings of The Council

Varied and Important Questions Considered at Regular and Special Meetings Held May 6 and 8 During Annual Meeting in Columbus

A REGULAR meeting of The Council of the Ohio State Medical Association was held at the Neil House, Columbus, Monday evening, May 6, 1946, the evening before the Centennial Anniversary Meeting of the Association. Dinner was served at 7 o'clock and following the dinner The Council held a regular business session. Those attending were: President Schriver, President-Elect McNamee, Past-President Sherburne, Treasurer Mitchell; Councilors Swartz, Messenger, Noble, Brindley, Dixon, Rutledge, Lincke, Swan, Micklethwaite, Clodfelter, and Knoble; chairmen of the standing committees of the Association; a number of special guests; and members of the Headquarters Office staff.

On **motion** by Dr. Sherburne, seconded by Dr. Brindley, and **carried**, the minutes of the last meeting of The Council held on March 10, 1946, **were approved.**

The Executive Secretary reported on membership as follows: Total membership as of May 6, 1946—6,787; compared to a total membership of 6,906 on December 31, 1945.

The Council reviewed the audit of the books of the Association and *The Journal* made by Keller, Kirschner, Martin & Clinger, certified public accountants, for the calendar year 1945 and published in the April issue of *The Journal.* On **motion** by Dr. Sherburne, seconded by Dr. Swan, and **carried**, the audit **was approved** and referred to the House of Delegates, scheduled to meet on May 7 and May 8.

REPORTS OF COUNCILORS

Members of The Council presented verbal reports on the activities in their respective districts.

At the conclusion of his report, Dr. Swan tendered his resignation as a member of The Council representing the Eighth District. On **motion** by Dr. Dixon, seconded by Dr. Sherburne, and **carried**, The Council accepted his resignation with regret and referred the question of filling the vacancy to the House of Delegates for action on May 8.

The Executive Secretary reported on arrangements for the Centennial Anniversary Meeting scheduled to open at 10:00 A.M., Tuesday, May 7.

FEDERAL LEGISLATION DISCUSSED

There was a general discussion of pending Federal legislation, including the Wagner-Murray-Dingell Bill. Dr. Schriver, Dr. Hein, and the Executive Secretary reported on a conference held with Senator Taft in Washington on March 28, 1946. Reference was made to the hearings now being held by the Senate Committee on Education and Labor on the Wagner-Murray-Dingell Bill. It was the sense of The Council that even though there appears to be little, if any, possibility of favorable action by Congress on this proposal at the present session of Congress, the situation should be watched very carefully and the Association should be prepared to take vigorous action in case the bill should come before either house of Congress for a vote.

NEW PROPOSAL CONSIDERED

The Council also discussed a proposal, Senate Bill 2143, introduced on May 5, 1946, by Senator Taft of Ohio, Senator Smith of New Jersey, and Senator Ball of Minnesota, proposing to coordinate the health functions of the Federal Government in a single agency, and to provide for financial assistance by the Federal Government to the various States for health, medical, hospital, and similar activities. As reported in the newspapers, this proposal is said to be a counter-proposal to the Wagner-Murray-Dingell Bill. An analysis of the measure was given to each member of The Council for study, and on **motion** by Dr. Knoble, seconded by Dr. Micklethwaite, and **carried**, action by The Council was deferred until the next meeting of The Council called for Wednesday, May 8.

HEALTH PROGRAM OUTLINED

The Council then reviewed in detail a proposed health program for Ohio, prepared on order of The Council at the Council meeting held on December 16, 1945. On **motion** by Dr. Mitchell, seconded by Dr. Lincke, and **carried**, the proposal **was approved** by The Council and referred to the House of Delegates for action on May 7-8. (See page 620, this issue for text of proposal subsequently adopted by the House of Delegates.)

ASK TERMINATION OF E. M. I. C. PLAN

Following a discussion of the E.M.I.C. Program and the Pepper Bill, S. 1318, The Council adopted a resolution recommending the termination of the E.M.I.C. Program on June 30, 1946, and protesting the enactment of Senate Bill 1318. Such action was taken on **motion** by Dr. Brindley, seconded by Dr. Swartz, and **carried**, and in such motion the resolution was referred

to the House of Delegates for consideration and action on May 7-8. (See page 631, this issue of *The Journal* for approval of resolution by House of Delegates.)

UNIFORM FEE TO BE PAID

A letter from Dr. Susan P. Souther, Chief of the Division of Child Hygiene, Ohio Department of Health, was read. In this letter it was pointed out that, pursuant to protests made by the Ohio State Medical Association and a number of county medical societies and other medical societies, the department had rescinded its previous action providing for a differential in fees paid to physicians caring for E.M.I.C. clients and that effective May 1 a uniform fee will be paid to all physicians participating in this program regardless of whether they are, or are not, diplomates of a specialty board.

RESOLUTION ON INCREASE IN DUES

On **motion** by Dr. Rutledge, seconded by Dr. Micklethwaite, and **carried**, The Council adopted a resolution for action by the House of Delegates on May 7-8, recommending that the per capita dues of the Ohio State Medical Association shall be increased from $7.00 to $15.00, effective January 1, 1947. (See page 631, this issue, for approval of resolution by the House of Delegates.)

V. A. MEDICAL CARE PROGRAM

The Executive Secretary reported that correspondence from the central office of the Veterans Administration, Washington, indicated that the proposal of the Ohio State Medical Association for a statewide program to provide medical care for disabled veterans, permitting free choice of physician by a veteran, is still under consideration by the Washington office but that there is every reason to believe that the program will be approved in the near future. There was a discussion of the machinery which would have to be set up when and if the program is approved and that in all probability a definite date when the program would become effective would be established by the branch office of the Veterans administration serving Ohio, Michigan, and Kentucky.

REPORT ON RURAL HEALTH MEETINGS

Dr. Carll S. Mundy, Toledo, chairman of the Committee on Rural Health, Dr. Jonathan Forman, Editor of *The Journal*, and Mr. Hart F. Page, News Editor of *The Journal*, reported on a national conference on rural health held in Chicago recently. They and the Executive Secretary also reported on a rural health conference held in Columbus a month ago in which representatives of the Ohio State Medical Association participated.

Correspondence setting forth complaints regarding an advertiser in *The Ohio State Medical Journal* was reviewed carefully by The Council. On **motion** by Dr. Brindley, seconded by Dr. Swartz, and **carried**, the business manager of *The Journal* was instructed to terminate the existing contract between *The Journal* and such advertiser at the earliest possible date in view of the complaints set forth in the letters read to The Council.

WANTS ADVISOR NAMED

A communication from Dr. Roger E. Heering, Ohio Director of Health, was read. In the letter Dr. Heering requested the Ohio State Medical Association to recommend a representative of the Association to be appointed on an Advisory Committee to assist the department in a program of evaluation of clinical pathological laboratories in connection with the performance of serodiagnostic tests for syphilis under the Ohio premarital and prenatal examination laws. On **motion** by Dr. Brindley, seconded by Dr. Noble, and **carried**, The Council authorized the President to name such a representative.

MILITARY SERVICE COMMITTEE AUTHORIZED

The Council discussed a letter from Dr. George F. Lull, Secretary and General Manager of the American Medical Association, requesting each state medical society to appoint a committee to be known as the Committee on Military Service. It was pointed out in Dr. Lull's letter that this committee would study communications received from physicians who served in the armed forces and would formulate policies for recommendations to the Surgeons General of the War and Navy Departments on the planning for proper utilization of the services of physicians in any future national emergency. It was suggested by Dr. Lull that the committee should include four civilian physicians who served in World War II and three others. On **motion** by Dr. Knoble, seconded by Dr. Messenger, and **carried**, the President was authorized to appoint such committee.

REINSTATEMENT QUESTION DISCUSSED

A question regarding reinstatement of a returned medical officer to his former employment, presented to The Council at its last meeting and deferred for consideration, was discussed. A memorandum on the matter, prepared by the Executive Secretary, was considered. On **motion** by Dr. Sherburne, seconded by Dr. Dixon, and **carried**, The Council expressed itself as believing that part of the question would be clarified automatically through the operation of the new program of the State Department of Health in approving clinical pathological laboratories on the basis of evaluation tests and that the matter of whether or not such physician was entitled to his former position with a local health depart-

ment is a question of law and can be decided only in event such physician should decide to appeal his case to the State Civil Service Commission for review and opinion.

REPORT ON OHIO MEDICAL INDEMNITY, INC.

Mr. Charles A. Coghlan, Executive Vice-President of Ohio Medical Indemnity, Inc., presented a brief verbal report on the status of the activities of the company in the Cincinnati area. Mr. Coghlan reported that to date the company had issued approximately 7,525 contracts covering approximately 18,712 persons. He also reported that Ohio Medical Indemnity, Inc., had been accepted as a charter member of Associated Medical Care Plans, Inc., the coordinating agency recently established by the American Medical Association.

TO NAME ADVISORY COMMITTEE

Dr. Heering and Dr. John Porterfield, chief of the Division of Venereal Diseases, Ohio Department of Health, discussed the present venereal disease program of the department. Dr. Porterfield suggested that it would be very helpful to the department if the Ohio State Medical Association would name an Advisory Committee to assist him and his division. On **motion** by Dr. Brindley, seconded by Dr. Dixon, and **carried**, the President was authorized to name such an Advisory Committee.

APPRECIATION TO DR. SCHRIVER

On **motion** by Dr. Lincke, seconded by Dr. Micklethwaite, and **carried**, The Council expressed its appreciation to Dr. Schriver, the retiring President, not only for the efficient manner in which he had presided at Council meetings but also for his splendid leadership in all of the activities of the Association during the past two years.

RESOLUTIONS OF SYMPATHY

By a rising vote The Council adopted a **motion** by Dr. Messenger, seconded by Dr. Lincke, and **carried**, expressing condolences and sympathy with respect to the recent death of Dr. C. W. Kirkland, Bellaire, former member of The Council representing the Seventh District, and the recent death of Mrs. George A. Woodhouse, Pleasant Hill, wife of Dr. Woodhouse, an Ohio delegate to the American Medical Association and a member of the Judicial and Professional Relations Committee and the Sub-Committee on Legislation.

There being no further business, The Council recessed to meet with the House of Delegates at 10:00 A.M., May 7.

Attest: CHARLES S. NELSON,
Executive Secretary.

SPECIAL MEETING OF THE COUNCIL

A special meeting of The Council was held at 12:00 Noon, May 8, 1946, following the final session of the House of Delegates. Those present were: President McNamee, President-Elect Rutledge, Past-President Schriver; Councilors Swartz, Messenger, Bowman, Brindley, Dixon, Davis, Lincke, Tronstein, Micklethwaite, Clodfelter, and Knoble, and Executive Secretaries Nelson and Saville.

President McNamee presented the following committee appointments which **were approved** on **motion** by Dr. Messenger, seconded by Dr. Micklethwaite, and **carried:**

Auditing and Appropriations—Dr. Carl A. Lincke, Carrollton, chairman; Dr. A. A. Brindley, Toledo; and Dr. Fred W. Dixon, Cleveland.

Woman's Auxiliary Advisory Committee—Dr. A. A. Brindley, Toledo, chairman; Dr. Gilbert Micklethwaite, Portsmouth; and Dr. H. M. Clodfelter, Columbus.

Committee on Medical Care of Veterans—Dr. Harry V. Paryzek, Cleveland, chairman; Dr. Robert Conard, Wilmington; Dr. D. W. Heusinkveld, Cincinnati; Dr. Paul I. Hoxworth, Cincinnati; Dr. Harry R. Huston, Dayton; Dr. Wm. W. Trostel, Piqua; Dr. W. W. Green, Toledo; Dr. Herbert B. Wright, Cleveland; Dr. Edgar Northrup, Marietta; Dr. Drew L. Davies, Columbus; Dr. Robert L. Eastman, Mt. Vernon; Dr. Frank F. Tallman, Columbus; Dr. John H. Marshall, Findlay; Dr. Gordon G. Nelson, Youngstown; Dr. Lewis W. Cellio, Carrollton; Dr. Charles L. Shafer, Mansfield; Dr. L. D. Allard, Portsmouth.

Committee on Rural Health—Dr. Carll S. Mundy, Toledo, chairman; Dr. Jonathan Forman, Columbus; Dr. W. B. Recker, Leipsic; Dr. E. G. Caskey, Mineral Ridge; Dr. Wm. B. Taylor, Jackson; Dr. James M. Snider, Marysville; Dr. H. T. Pease, Wadsworth; Dr. A. D. Harvey, Lebanon; Dr. L. E. Anderson, Greentown.

Sub-Committee on Legislation—Dr. Ralph M. Watkins, Cleveland, chairman; Dr. Emil R. Swepston, Cincinnati; Dr. G. A. Woodhouse, Pleasant Hill; Dr. Floyd M. Elliott, Ada; Dr. D. J. Slosser, Defiance; Dr. John M. Van Dyke, Canton; Dr. Jay W. Calhoon, Uhrichsville; Dr. R. G. Plummer, Newark; Dr. Clyde M. Fitch, Portsmouth; Dr. Donald Bowers, Columbus; Dr. George F. Linn, Norwalk.

Committee on Industrial Health and Workmen's Compensation—Dr. H. P. Worstell, Columbus, chairman; Dr. Barney J. Hein, Toledo; Dr. F. G. Barr, Dayton; Dr. George F. Sykes, Cleveland; Dr. Robt. A. Kehoe, Cincinnati; Dr. Louis N. Jentgen, Columbus; Dr. John M. Van Dyke, Canton; Dr. James N. Wychgel, Cleveland.

Sub-Committee on Public Health Education—Dr. Carl A. Wilzbach, Cincinnati, chairman; Dr. F. L. Shively, Dayton; Dr. Jonathan Forman, Columbus; Dr. C. W. Wyckoff, Cleveland; Dr.

Robt. T. Allison, Akron; Dr. M. D. Shilling, Ashland.

Committee on Medical Service Plans—Dr. Robert C. Rothenberg, Cincinnati, chairman; Dr. Wm. M. Skipp, Youngstown; Dr. Jonathan Forman, Columbus; Dr. R. K. Finley, Dayton; Dr. Robert E. S. Young, Columbus; Dr. Carll S. Mundy, Toledo; Dr. Reyburn McClellan, Xenia; Dr. Azel Ames, Jr., Hamilton; Dr. Farrell T. Gallagher, Lakewood.

Consideration was given to the proposal introduced in the United States Senate by Senator Taft, action on which had been deferred at the Council meeting on Monday evening, May 6. On motion by Dr. Knoble, seconded by Dr. Mickleth-waite, and carried, The Executive Secretary was instructed to obtain copies of the proposal for distribution to members of The Council and members of The Council were requested to submit in writing to the Columbus office their views and opinions regarding the measure.

There being no further business, The Council adjourned to meet at the call of the President.

Attest: CHARLES S. NELSON,
Executive Secretary.

Two Health Education Institutes Planned by University of Cincinnati

During the Summer Session, the University of Cincinnati is presenting two health education institutes on the campus intended to provide information and guidance for persons concerned with health problems, including public health workers, classroom teachers, specialists in health and physical education, school administrators, volunteer and professional social workers, workers in youth agencies, and other community leaders.

A School and Community Health Education Institute, June 17-29, is devoted to methods and materials in the modern school and community health education program, based on the new Ohio Department of Education course of study in health education. Topics to be presented and discussed include: general and special teaching methods, personal health standards and evaluations, personal patterns of everyday living, mental hygiene, nutrition, correction of defects, public health practices and disease control, accident prevention, home nursing skills, and social hygiene.

The director of the institute will be Miss Helen Norman Smith, professor of physical and health education, University of Cincinnati. She will be assisted by Dr. Helen L. Coops, supervisor of health education, State Department of Education. Invited specialists include: Dr. Susan Souther, chief, Division of Child Hygiene, State Department of Health; Dr. Harry Wain, Troy, health commissioner of Miami County; Dr. Carl Wilzbach, health commissioner of Cincinnati; and Paul Landis, supervisor of health physical education, and recreation, State Department of Education.

This institute is presented in cooperation with the Ohio Department of Health and the Ohio Department of Education. It is endorsed by the Ohio Congress of Parents and Teachers.

A Social Hygiene Institute, July 1-6, will be concerned primarily with measures contributing to successful marriage and family life. Topics to be considered include: present-day conditions and needs; modern social hygiene concepts; problems of parent education; techniques of counseling; class room procedures; public health and medical aspects; mobilizing community resources; social protection; special problems of youth; and the program of the church.

Under the general direction of Roy E. Dickerson, executive secretary of the Cincinnati Social Hygiene Society, the teaching staff of this institute will include: Dr. Paul Popenoe, Director of the American Institute of Family Relations; Dr. Eugene A. Gills, United States Public Health Service; Dr. John D. Porterfield, Ohio Department of Health; Dr. Wilzbach; Dr. Coops; and Dr. Dwight Scott of the Cincinnati Social Hygiene Society.

The Social Hygiene Institute is sponsored by the Cincinnati and American Social Hygiene Societies, and conducted in cooperation with the U. S. Public Health Service, the American Institute of Family Relations, the Ohio Department of Health, and the Ohio Department of Education. It is endorsed by the Ohio Congress of Parents and Teachers.

A complete Summer Session catalogue, with detailed information concerning tuition rates and dormitory accommodations, will be sent on request addressed to: Dr. Gordon Hendrickson, acting director, Summer Session, University of Cincinnati, Cincinnati 21.

Fellowships in Public Health

The U. S. Public Health Service has announced that a grant for the establishment of 125 fellowships to train physicians and sanitary engineers in public health has just been approved by the National Foundation for Infantile Paralysis. Each fellowship provides a year's graduate training in a school of public health or a school of sanitary engineering. The fellowships are available either during the academic year beginning in the fall of 1946 or the fall of 1947, and are open to men and women, citizens of the United States under 45 years of age. Applicants for fellowships may secure further details by writing to the Surgeon General, U. S. Public Health Service, Attention: Public Health Training, 19th and Constitution Avenue N. W., Washington 25, D. C.

Total Registration at Centennial Anniversary Meeting 2,121; Names of Members Attending and Other Figures

TABULATION of registration cards shows that a total of 2,121 persons attended the Centennial Anniversary Meeting of the Ohio State Medical Association, May 7, 8, and 9, Columbus.

A breakdown of the registration figures shows that 1,262 members registered. The figures on other classifications of registrants are: Out-of-state physicians, 23; guests, 679, including 107 interns, residents, and guests physicians and 65 medical students; exhibitors, 157.

Following are registration figures for Annual Meetings held from 1919 to 1946, inclusive; registration by counties for the 1946 meeting and membership data; and the names of members of the Association who registered:

Annual Meeting Registration For 1919-1946, Inclusive

Year	Place	Members	Out-of-State Physicians	Guests	Technical Exhibitors	Total
1919	Columbus	1173	10	264	92	1529
1920	Toledo	810	17	105	80	1062
1921	Columbus	1275	28	204	96	1503
1922	Cincinnati	1066	21	184	70	1341
1923	Dayton	1117	19	202	76	1414
1924	Cleveland	1301	13	180	109	1603
1925	Columbus	1204	17	361	107	1689
1926	Toledo	903	19	120	83	1125
1927	Columbus	1320	17	286	82	1705
1928	Cincinnati	916	27	92	80	1116
1929	Cleveland	1231	15	249	124	1619
1930	Columbus	1241	13	435	86	1775
1931	Toledo	826	13	198	50	1087
1932	Dayton	978	2	201	45	1226
1933	Akron	858	6	160	25	1049
1934	Columbus	1069	9	410	51	1539
1935	Cincinnati	973	17	197	84	1271
1936	Cleveland	1099	14	563	137	1813
1937	Dayton	1103	18	366	64	1551
1938	Columbus	1330	15	619	104	2068
1939	Toledo	1056	15	271	84	1426
1940	Cincinnati	1126	26	323	114	1589
1941	Cleveland—Joint Meeting with A.M.A.					
1942	Columbus	1221	13	527	119	1880
1943	Columbus	544	13	160	-----	717
1944	Columbus	830	20	441	130	1421
1945	No Meeting					
1946	Columbus	1262	23	679	157	2121

Registration, 1946 Annual Meeting, by Counties and Membership Data

County	Total Membership Dec. 31, 1945	Total Membership May 1, 1946	Annual Meeting Registration
Adams	14	14	5
Allen	73	84	28
Ashland	23	23	5
Ashtabula	50	49	1
Athens	27	29	9
Auglaize	22	21	6
Belmont	56	57	10
Brown	4	4	-----
Butler	93	96	15
Carroll	9	9	2
Champaign	20	21	5
Clark	81	78	17
Clermont	27	23	1
Clinton	23	23	11
Columbiana	57	53	8
Coshocton	24	20	10
Crawford	29	30	10
Cuyahoga	1417	1429	101
Darke	23	23	7
Defiance	16	15	2
Delaware	19	19	11
Erie	42	40	5
Fairfield	38	39	14
Fayette	14	17	8
Franklin	609	603	334
Fulton	20	16	2
Gallia	19	18	-----
Geauga	12	13	2
Greene	35	32	6
Guernsey	28	32	9
Hamilton	946	918	63
Hancock	41	40	9
Hardin	20	22	2
Harrison	16	12	3
Henry	15	15	2
Highland	24	25	9
Hocking	13	14	9
Holmes	10	10	4
Huron	27	25	3
Jackson	9	8	-----
Jefferson	61	62	2
Knox	28	27	7
Lake	37	31	3
Lawrence	23	25	7
Licking	48	51	20
Logan	24	20	4
Lorain	114	118	5
Lucas	412	360	43
Madison	17	14	6
Mahoning	227	219	28
Marion	46	49	15
Medina	30	29	7
Meigs	14	14	5
Mercer	17	14	1
Miami	50	48	23
Monroe	4	4	1
Montgomery	359	358	71
Morgan	8	6	1
Morrow	8	8	5
Muskingum	48	40	14
Ottawa	19	16	3
Paulding	12	12	1
Perry	17	15	6
Pickaway	17	16	7
Pike	7	7	4
Portage	28	28	4
Preble	12	12	4
Putnam	20	18	5
Richland	81	80	16
Ross	42	42	18
Sandusky	36	39	3
Scioto	63	64	17
Seneca	35	34	9
Shelby	21	20	3
Stark	221	217	42
Summit	328	323	41
Trumbull	77	75	8
Tuscarawas	53	52	14
Union	13	13	6
Van Wert	24	26	4
Vinton	4	5	---
Warren	17	16	4
Washington	28	31	9
Wayne	41	43	4
Williams	18	18	3
Wood	39	37	6
Wyandot	13	12	5
Totals	6906	6787	1262

Members of State Association Registered at 1946 Meeting

Adams County—Sam Clark, R. B. Ellison, S. J. Ellison, Hazel L. Sproull, R. C. Wenrick. **Allen County**—Harvey L. Basinger, Walter C. Beery, Wm. H. Beery, Margaret E. Belt, H. H. Brueckner, K. G. Hawver, F. A. Hemsath, J. R. Johnson, Chas. H. Leech, W. B. Light, W. B. Ludwig,

Walter A. Noble, Alfred W. Pinkerton, Karl F. Ritter, O. S. Robuck, C. E. Savage, M. D. Soash, M. M. Sondheimer, C. L. Steere, David L. Steiner, H. L. Stelzer, Paul J. Stueber, John E. Talbott, Roger L. Tecklenberg, H. A. Thomas, J. R. Tillotson, B. W. Travis, H. C. Weisenbarger.

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Stark County—S. L. Agnone, L. E. Anderson, Edward Arnold, J. E. Aten, A. R. Basinger, F. P. Bennett, B. R. Bonnot, H. H. Bowman, J. R. Brandon, Joseph J. Brumbaugh, John R. Caldwell, Roy H. Clunk, William E. Elliott, S. J. Feingold, L. L. Frick, Ian B. Hamilton, Mark G. Herbst, H. I. Keck, George L. King, Abe A. Lichtblau, Joseph E. McNalley, John D. O'Brien, A. R. Olmstead, C. O. Paradis, Louis S. Persell, Otto L. Plaut, George D. Popoff, J. Edwin Purdy, Raymond S. Rosedale, R. L. Rutledge, C. J. Schirack, M. A. Schlott, L. D. Stoner, G. Otho Thompson, R. L. Thompson, John M. Van Dyke, A. W. Warren, Homer V. Weaver, Howard B. Weaver, Geo. H. Wenger, George M. Wilcoxon, Pauline Zinninger.

Akron and Summit County—C. R. Andersen, E. R. Blower, Frank H. Bly, R. A. Breckenridge, Derwin D. Daniels, P. A. Davis, Arthur Dobkin, Patrick C. Doran, Robert J. Ferris, Floyd J. Fowler, C. H. Franks, J. W. German, R. A. Gregg, Carrie A. Herring, F. A. Johnson, W. M. Johnston, Harvey A. Karam, Walter A. Keitzer, J. G. Kramer, R. M. Lemmon, C. N. Long, V. C.

Malloy, E. L. Mather, C. T. McCormish, D. M. McDonald, S. J. Michaels (Columbus), John E. Monnig, M. C. Morgan, Ellis L. Noble, Carl C. Nohe, Chas. C. Pinkerton, R. C. Pinkerton, Dallas Pond, John Repasky, E. R. Shaffer, H. Vern Sharp, J. E. Springer, Joseph M. Ulrich, Edward L. Voke, Kurt Weidenthal, L. A. Witzeman.

Trumbull County—David L. Beers, S. A. Brown, J. H. Caldwell, R. D. Herlinger, Francis T. Kandrac, David R. Mathie, Clyde W. Muter, R. L. Thomas. **Tuscarawas County**—W. R. Agricola, David H. Allen, Jay W. Calhoon, D. M. Ceramella, W. W. H. Curtiss, E. C. Davis, D. H. Downey, G. I. Goodrich, Roy D. Hildebrand, Paul D. Hisrich, C. J. Miller, Elizabeth Rowland-Aplin, Harold F. Wherley, F. C. Yeager. **Union County**—Fred C. Callaway, P. D. Longbrake, Angus MacIvor, E. J. Marsh, James M. Snider, John M. Wilkins. **Van Wert County**—S. A. Edwards, J. R. Jarvis, Charles Mowry, J. B. Sampsell. **Warren County**—Orville L. Layman, Arthur F. Lippert, Leonard Mounts, Robert M. Wilson.

Washington County—Charles C. Deamude, W. S. Hawn, E. W. Hill, Jr., G. E. Huston, J. A. McCowan, M. S. Muskat, W. E. Radcliff, W. W. Sauer, W. D. Turner. **Wayne County**—Bernard M. Foster, F. C. Ganyard, H. J. Mitchell, Vincent C. Ward. **Williams County**—C. G. Goll, Paul G. Meckstroth, H. W. Wertz. **Wood County**—F. V. Boyle, E. D. Foltz, F. D. Halleck, H. W. Mannhardt, Helen B. Todd, R. N. Whitehead. **Wyandot County**—J. Craig Bowman, B. A. Moloney, R. J. Semons, F. M. Smith, John M. Thompson.

Narcotic License Must Be Renewed By July 1 to Avoid Penalty

On or before July 1 every physician registered under the Harrison Narcotic Act, must, unless he is in military service, re-register with the Collector of Internal Revenue of the district in which he maintains an office, and pay the Federal Narcotic Tax of $1.00. Initial applications may be made at any time, but existing permits must be renewed on or before July 1, annually.

Failure to re-register within the time allowed by law adds a penalty of 25 per cent to the annual tax, and in addition makes the physician liable to a fine not exceeding $2,000 or to imprisonment for not more than five years or both. In recent years the Commissioner of Internal Revenue has given some tardy registrants the choice between paying sums by way of compromise in lieu of the penalties for their offenses, or as an alternative, accepting criminal prosecution, with resultant publicity and liability to fines and possible imprisonment. Strict adherence to the law will obviate the necessity for such action and protect the physician from needless embarrassment.

Copies of the forms for re-registration have been mailed by the District Collectors of Internal Revenue to each Ohio physician already registered, with brief instructions of the procedure to be followed. **For several years the collectors sent a second notice about June 15 to physicians who failed to re-register. This was discontinued three years ago, and there will be no reminder this year.**

Application for re-registration must be made on Form 678, signed by the physician applying, and either acknowledged by two qualified witnesses or sworn to by a Notary Public or an official of the Internal Revenue Department. The physician must note on his application the number of his license to practice medicine in Ohio. The registration number assigned by the Department of Internal Revenue is retained from year to year. **Remittance accompanying the application may be in the form of cash, a postal money order or certified check. Personal checks, not certified, will be returned to the sender.**

An inventory of the narcotic drugs on hand in the physician's office must accompany the application, on Form 713. The regulations require that this inventory must be sworn to by a Notary Public or an official of the Internal Revenue Department regardless of the quantity of drugs on hand.

Physicians who administer, dispense or prescribe cannabis, must obtain a special permit under the Marihuana Tax Act, and re-register annually on or before July 1, with the Collector of Internal Revenue of his district, and pay a tax of $1.00.

A physician in the armed forces need not re-register. If such a physician should receive an application form for re-registration he should return it to the office of the Collector of Internal Revenue from which it was sent, together with a statement that he is in the armed forces, that he does not have in his possession any narcotics, and requesting that the registration number previously assigned to him be reserved.

Upon his return to civilian practice, a physician who has been in military service must immediately apply for registration. He will be assigned his former registration number.

Naturopaths Convicted

William Henning and his wife, both of Columbus, and Keith E. Good, Cleveland, were arrested for alleged violation of the Medical Practice Act, and brought before the Columbus Municipal Court on May 8. Henning was found guilty and fined $250 and costs. This verdict and the sentence were also applied to Mrs. Henning and to Good. Appeal was made to the Common Pleas Court. The case of A. L. Allen, Cincinnati, who was convicted of the same charge by the Municipal Court of Cincinnati on November 1, 1945, and fined $500 and costs, has also been appealed to Common Pleas Court.

All were engaged in the practice of naturopathy, a practice which is not covered by the Ohio law.

Woman's Auxiliary Holds Annual Meeting; Report of Business Transacted; New Officers and Directors

THE Deshler-Wallick Hotel, Columbus, was headquarters for the annual meeting of the Woman's Auxiliary on Tuesday, Wednesday, and Thursday, May 7, 8, and 9, 1946. Mrs. Roswell S. Fidler, Columbus, president, conducted the business sessions. Mrs. Ralph W. Hoffman, Columbus, general chairman for the convention, left nothing undone to make it a memorable occasion.

Mrs. George Cooperrider, president of the Columbus Auxiliary and chairman of hostesses, with her staff of assistants, welcomed the guests. Mrs. Paul A. Davis, Akron, president-elect and the incoming president, assisted Mrs. Fidler in assuming the responsibilities incident to the success of the business and social activities.

BUFFET SUPPER

A buffet supper was held at 7 P.M., Tuesday, at the Deshler-Wallick Hotel, in honor of the presidents of the county auxiliaries, with Mrs. J. L. Stevens, Mansfield, immediate past-president of the Ohio Auxiliary, acting as hostess. A corsage was presented to each president by the Columbus Auxiliary hostesses. Following the supper, bridge games were enjoyed with the contestants receiving unusual prizes. Mrs. F. A. Riebel headed the committee on arrangements for this affair.

DR. McCORMICK SPEAKS

Mrs. Dale P. Osborn, Cincinnati, acted as hostess at the breakfast Wednesday morning, and introduced Dr. E. J. McCormick, Toledo, whose timely subject was "The National Program Adopted by the American Medical Association".

At a luncheon held at 1 P.M. the same day, in honor of Mrs. Fidler, the guest speaker was Dr. Jonathan Forman, editor of *The Ohio State Medical Journal*, who told the story of "One Hundred Years of Organized Medicine in Ohio". Mrs. M. E. Millhon, Columbus, acting as hostess, presented a bouquet of flowers to Mrs. Fidler from the Columbus Auxiliary.

Concluding a most interesting day, Auxiliary members and guests joined the members of the Ohio State Medical Association at the Centennial Banquet, held at 7 P.M. in the Neil House.

At the opening of the business session Thursday, an impressive memorial service for deceased auxiliary members was conducted by Mrs. W. W. H. Curtiss, Dennison, a past-president. Mrs. George Wilcoxon, Alliance, sang "Abide With Me".

NEW OFFICERS AND DIRECTORS

A report of the nominating committee was presented by Mrs. Ross Hill, Middletown, chairman. The following officers were elected: Mrs. Harold K. Mouser, Marion, president-elect; Mrs. R. L. Rutledge, Alliance, vice-president; Mrs. E. B. Gillette, Toledo, secretary; Mrs. Dean Nesbit, Youngstown, treasurer.

District directors are, in order of their districts: Mrs. W. B. Roads, Hillsboro; Mrs. E. P. Trittschuh, Lewisburg; Mrs. J. R. Tillotson, Lima; Mrs. Rollin Kuebbeler, Toledo; Mrs. A. M. Mills, Ashtabula; Mrs. J. J. McDonough, Youngstown; Mrs. J. W. Calhoon, Uhrichsville; Mrs. T. R. Mattocks, Marietta; Mrs. G. E. Neff, Portsmouth; Mrs. George Cooperrider, Columbus; and Mrs. C. H. Bell, Middletown.

Directors-at-large are: Mrs. C. F. Wharton, Akron; Mrs. Fred Brosius, Middletown; Mrs. David Beers, Warren; Mrs. J. L. Stevens, Mansfield; Mrs. David Keating, Cleveland; and Mrs. B. C. Diefenbach, Martins Ferry.

Mrs. Stevens, a past-president of the State Auxiliary, installed the officers, including Mrs. Davis, the new president.

LUNCHEON HONORING PRESIDENT

The new president, Mrs. Davis, was honored at a luncheon held at noon Thursday. Mrs. Fidler who presided, was awarded a beautiful gift as a remembrance from the State Auxiliary members for her faithful service during the past two years. Mrs. C. F. Wharton, president of the Akron Auxiliary, was hostess, and presented Mrs. Davis with a beautiful bowl of flowers. The unique program, "Mrs. Doctor in the Community", related the personal experiences of the following participants: Mrs. Frank McNierney, Toledo; Mrs. Gerald Castle, Cincinnati; Mrs. L. A. Witzeman, Akron; Mrs. George E. Neff, Portsmouth; and Mrs. Fred Brosius, Middletown.

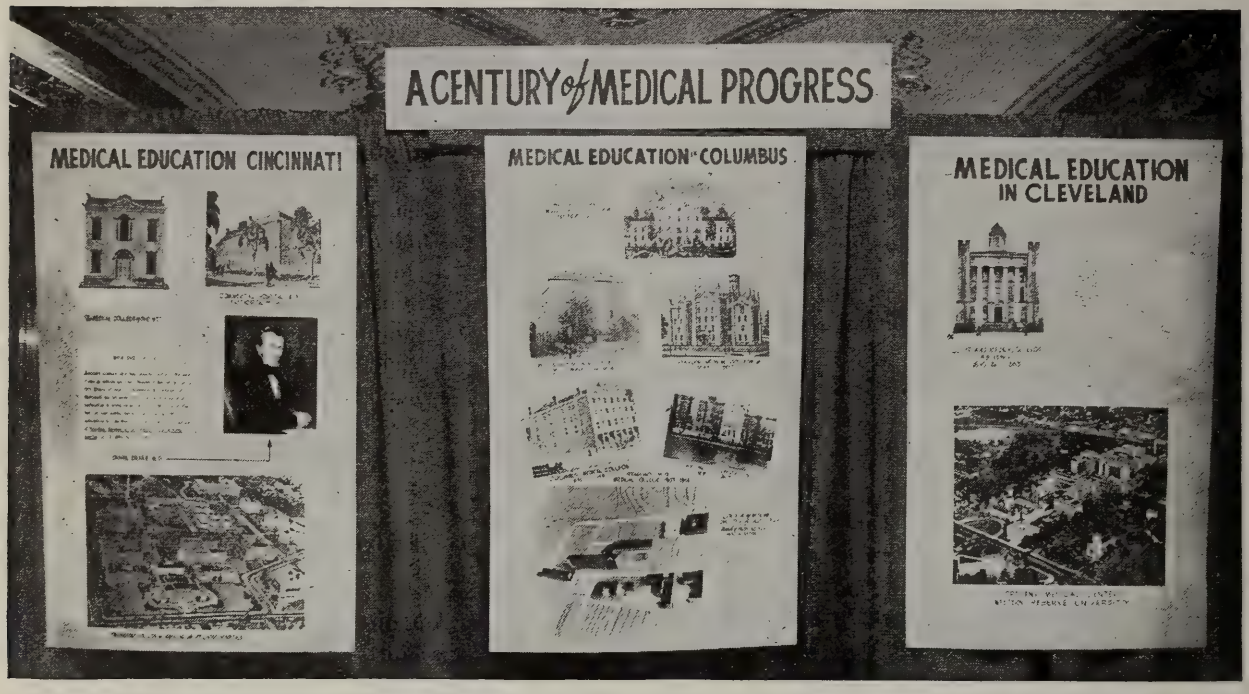
Adding to the success of the convention were the following committees: registration, Mrs. Nesbit, Mrs. C. W. Pavey, Columbus, Mrs. R. E. Krigbaum, Columbus, and Mrs. E. J. Stedem, Columbus; tickets, Mrs. John Riebel, Columbus, and Mrs. W. J. Miller, Columbus; publications and displays, Mrs. Mouser; publicity, Miss Allyne Stout, Columbus. Mrs. C. M. Valentine, Columbus, served as parliamentarian.

Mrs. Earl H. Baxter, president-elect of the Columbus Auxiliary, was one of the prominent hostesses. Deep appreciation is expressed by the out-of-town guests for the warm hospitality and personal interest shown by the Columbus Auxiliary members.

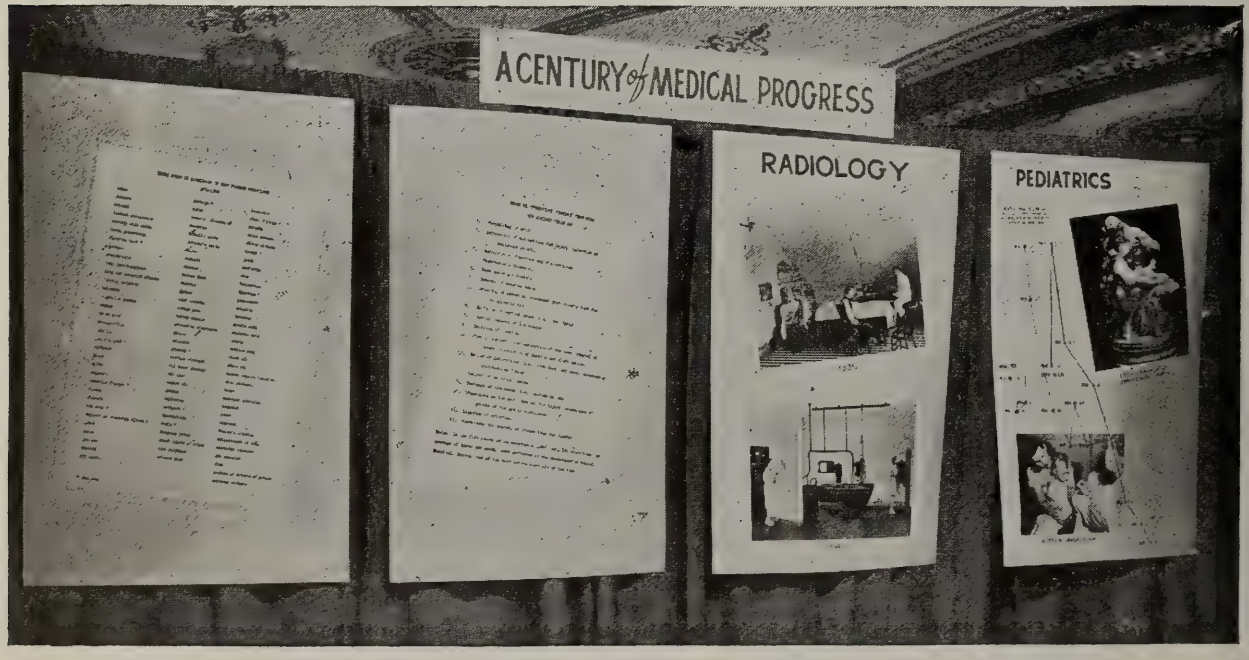
The State Auxiliary accepted as its official emblem, a modified caduceus designed by Mrs. John Riebel. Mrs. Riebel had originally designed the emblem for the Auxiliary to the Columbus Academy of Medicine.

A Century of Progress In Medicine . . .

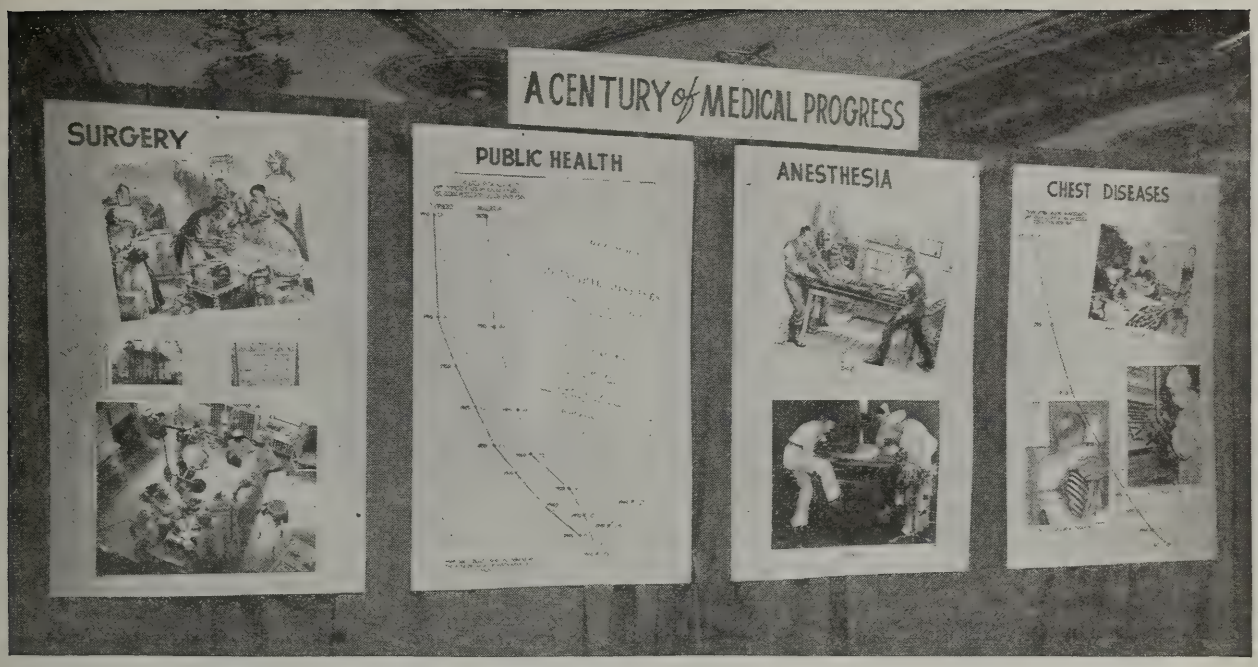
ONE of the features of the Centennial Anniversary Meeting of the Ohio State Medical Association, May 7, 8, and 9, Columbus, was a historical exhibit, depicting outstanding events and developments in the science and art of medicine during the past 100 years. Presented here on this and the next page are photographs of the exhibits.



In the first group, the first panel concerns medical education in Cincinnati; shows the first school and hospital; shows picture and history of Daniel Drake, M.D., and view of present medical center. Second panel pictures development of the Ohio State University College of Medicine from Willoughby of Lake Erie to the proposed new health center. Third display describes development of Western Reserve University from the first building to present center and hospitals.

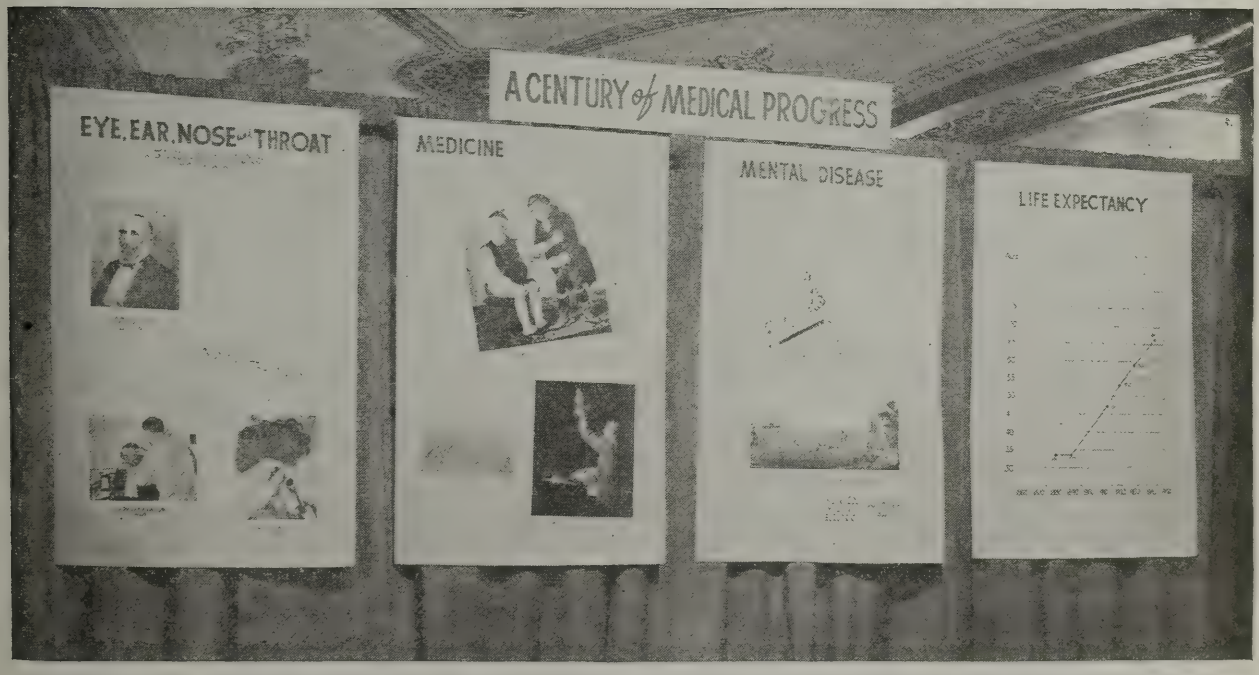


In the second group, the first panel lists the drugs found in the saddlebags of Ohio Pioneer Physicians from 1830 to 1846. Obsolete drugs are marked. The second panel lists surgical operations commonly performed 100 years ago. The third shows old and new radiological equipment



in use, the top picture being dated 1895. The fourth, concerning pediatrics includes a statue of Jenner inoculating a baby for smallpox, and a present day immunization scene; graphs showing decline in mortality from diphtheria and smallpox.

In the third group, the first panel shows a surgical operation scene 100 years ago, and one of today; also a photo of the monument to John Lambert Richmond, M.D., who performed the first Caesarian section in America at Newton, Ohio, April 22, 1827. The second panel shows a picture of the title page of Dr. Drake's *Principal Diseases of the Interior Valley of North America* and quotes from the book. Graphs show decline in malaria and typhoid fever mortality. The third panel shows how anesthesia makes a difference in operations of 100 years ago, and those of today. The fourth concerns chest diseases, from no therapy at all for tuberculosis to collapse therapy. Graphs show decline in mortality.



The fourth group, first panel, pictures Elkanah Williams, M.D., Cincinnati, who introduced the ophthalmoscope to America in 1855 shows use of modern instruments. The second panel contrasts early process of bleeding, with present-day transfusion of blood into the body. The third contrasts old methods of treating mental illness, with those of today. The fourth is a graph indicating how medicine has added years to the life of the average man.

Historic Meeting of State Association Attracts Record Attendance; Scientific Program Excellent

ATTRACTED by the historical significance of the event and by an exceptionally educational and interesting scientific program 2,121 persons registered their attendance at the Ohio State Medical Association's Centennial Anniversary Meeting held at the Neil House and Deshler-Wallick Hotel, Columbus, May 7, 8, and 9.

Although the historical theme connected with the 100th birthday of the Association was prevalent throughout this first post-war meeting, the delegates of the organization not only were interested in the rich history of a century of medical accomplishment, but by their words and actions, demonstrated a real desire for new achievements in the field of organized medicine.

PROGRESSIVE ACTION TAKEN

Results of proposals enacted by the House of Delegates, therefore, included plans for the future expansion of organizational activities and service in Ohio and a well-defined and forward-looking organizational program.

Subject of much comment from the press and organized groups throughout the State was the 25-point "Health Program for Ohio" adopted by the House of Delegates. This program included recommendations on nutrition, medical care, working conditions, smoke abatement, stream pollution, and other health factors necessary to better health of the people of the State.

TRIBUTE TO SERVICE MEN

This meeting, too, was the occasion for paying tribute to the 3,120 Ohio physicians who served with the armed forces and with various wartime governmental agencies during the recent war. Many of these men were in attendance at the meeting, and their return was due cause for celebration.

Dr. Edgar P. McNamee, Cleveland, succeeded Dr. Schriver as president during the meeting, and the following new officers and Councilors were elected: Dr. R. L. Rutledge, Alliance, president-elect; Dr. H. P. Worstell, Columbus, treasurer; Dr. J. Craig Bowman, Upper Sandusky, Third District Councilor; Dr. Paul A. Davis, Akron, Sixth District Councilor; and Dr. A. J. Tronstein, Newark, Eighth District Councilor.

DISTINGUISHED GUEST SPEAKERS

Out-of-state speakers for this year's meeting included: Dr. Homer F. Swift, Rockefeller Institute for Medical Research, New York City, speaking on "Relationship Between Rheumatic Fever and Hemolytic Streptococcal Infections"; Dr. Stanley P. Reimann, director of the Research Institute, Lankenau Hospital, Philadelphia, "Present Status of Cancer Research".

Dr. Walter L. Palmer, professor of medicine, University of Chicago, "Medical Management of Gastro-Intestinal Disturbances"; Dr. Roy D. McClure, chief surgeon, Henry Ford Hospital, Detroit, "The Surgical Treatment of Bleeding Peptic Ulcer and Gastric Cancer"; Dr. Carl V. Moore, associate professor of medicine, Washington University School of Medicine, St. Louis, "Recent Advances in the Understanding and Therapy of Anemias".

Dr. William H. Feldman, associate professor of comparative pathology, Mayo Foundation of the Graduate School, University of Minnesota, Rochester, Minnesota, "Evidence of Therapeutic Effects of Streptomycin in Experimental Tuberculosis"; and Brig. Gen. William C. Menninger, director, Neuropsychiatry Consultants Division, Office of the Surgeon General, United States Army, "Readjustment of the Disabled Veteran to Civilian Life".

The above papers as well as those presented by the members of the Association at the general and section meetings will be published in *The Ohio State Medical Journal.*

PAST-PRESIDENTS HONORED

The Centennial Anniversary Banquet, attended by almost 500, was addressed by Philip D. Jordan, Ph.D., associate professor of history, University of Minnesota, who presented a scholarly and interesting review of the medical panorama, completely fitting for the historical theme of the occasion.

All but two of the living past-presidents of the Association were present and were honored at the banquet. They were: Dr. J. H. J. Upham, Columbus; Dr. W. E. Lower, Cleveland; Dr. Charles Lukens, Toledo; Dr. Robert Carothers, Cincnnati; Dr. D. C. Houser, Urbana; Dr. Herbert M. Platter, Columbus; Dr. Clyde L. Cummer, Cleveland; Dr. John A. Caldwell, Cincinnati; Dr. Barney J. Hein, Toledo; Dr. William M. Skipp, Youngstown; Dr. Harry V. Paryzek, Cleveland; Dr. E. J. McCormick, Toledo; and Dr. C. C. Sherburne, Columbus.

The musical program of the banquet included several selections by the Chapel Choir, Capital University, Columbus, directed by Ellis E. Snyder. The choir was excellent and its performance well received. Dinner music was furnished by a string trio of the Columbus Philharmonic Orchestra. President L. H. Schriver

was toastmaster for the banquet, and received the past-president's gavel during the program.

REVIEW OF SCIENTIFIC SESSIONS

Dr. Charles A. Doan, dean of the College of Medicine, Ohio State University, presided at the first general session, which included papers by Dr. Swift; Dr. Walter J. Zeiter, Cleveland; Dr. Thomas P. Sharkey, Dayton; Dr. Allan C. Barnes, Columbus; Dr. W. J. Gardner, Cleveland; and Dr. A. B. Brower, Dayton.

At the second general session, Dr. Frank F. Tallman, Columbus, State Commissioner of Mental Hygiene, outlined a mental hygiene program for Ohio, and Dr. Reimann presented his paper.

At the third general session, with Dr. Louis G. Hermann, Cincinnati, presiding, papers were read by Dr. Palmer, Dr. McClure, Dr. Moore, Dr. Feldman, Dr. Charles F. McKhann, Cleveland, and General Menninger.

SECTION MEETINGS WELL ATTENDED

The section meetings were an outstanding success, with full attendance until the time of adjournment Thursday noon. Some of the sections reported standing room only existing at their meetings. The quiz-discussion feature of the sessions was extremely popular and some lively debates were encountered in several of the sections.

Officers and essayists of the section programs were as follows:

Section on Medicine—Dr. R. C. Rothenberg, Cincinnati, chairman; Dr. F. M. Wiseley, Findlay, secretary; Dr. Herman A. Hoster, Columbus; Dr. J. Harold Kotte, Cincinnati; Dr. Robert F. Parker, Cleveland.

Section on Eye, Ear, Nose, and Throat—Dr. Harry C. Rosenberger, Cleveland, chairman; Dr. Edward R. Thomas, Dayton, secretary; Dr. Harold E. Harris, Cleveland; Dr. Albert L. Brown, Cincinnati; Dr. Harry H. Haggart, Cincinnati; Dr. Donald J. Lyle, Cincinnati; Dr. J. W. McCall, Cleveland; and Dr. A. D. Ruedemann, Cleveland.

Section on Obstetrics and Gynecology—Dr. M. D. Haag, Toledo, chairman; Dr. R. Dean Dooley, Dayton, secretary; Dr. Joseph H. Prince, Dayton; Dr. Charles W. Pavey, Columbus; Dr. Wynne M. Silbernagel, Columbus; and Dr. Robert C. Austin, Dayton.

Section on Nervous and Mental Diseases—The program included a luncheon at noon, May 8, with General Menninger and Dr. Tallman as informal speakers. Dr. John M. Wittenbrook, Cleveland, chairman; Dr. E. H. Crawfis, Cleveland, secretary; Dr. R. E. Pinkerton, Akron; Dr. Elmer Haynes, Toledo; Dr. Henry C. Schumacher, Cleveland; Dr. G. H. Williams, Jr., Cleveland; Dr. E. M. Zucker, Cleveland; Dr. Louis A. Lurie, Cincinnati; Dr. J. L. Fetterman, Cleveland; Dr. Edgar L. Braunlin, Dayton; Dr. Charles L. Anderson, Worthington; Dr. Nicholas Michael, Columbus.

Section on Surgery—Dr. William Kelley Hale, Wilmington, chairman; Dr. J. Edwin Purdy, Canton, secretary; Dr. Carroll C. Dundon, Cleveland; Dr. John A. Caldwell, Cincinnati; Dr. George M. Curtis, Columbus; Dr. Frederick R. Mautz, Cleveland; Dr. E. J. McCormick, Toledo; and Dr. Thomas E. Jones, Cleveland, the moderator.

Section on Pediatrics—Dr. James G. Kramer, Akron, chairman; Dr. Samuel Edelman, Columbus, secretary; Dr. Robert A. Lyon, Cincinnati; Dr. Earl H. Baxter, Columbus; Dr. Charles F. McKhann, Cleveland; and Dr. C. W. Wyckoff, Cleveland.

Section on Public Health and Preventive Medicine—Dr. Carl A. Wilzbach, Cincinnati, chairman; Dr. W. D. Bishop, Greenville, secretary; Dr. Mark W. Garry, Columbus; Dr. Roger E. Heering, State Director of Health; Bleecker Marquette, Cincinnati.

SPECIAL SOCIETIES MEET

Special society meetings included that of the Ohio Society of Anesthetists; the Ohio State Radiological Society; the Ohio Society of Pathologists; and the Ohio chapter of the American College of Chest Physicians.

An exhibit of 15 panels portraying the history of 100 years of medical progress in Ohio was the feature of the historical exhibit which was presented by a committee of Dr. Jonathan Forman, Columbus, chairman; Dr. Howard Dittrick, Cleveland; and Dr. David A. Tucker, Jr., Cincinnati. A total of 62 technical exhibits added to the interest of the meeting.

President Truman has vetoed HR 3755, proposing to establish an Optometry Corps in the Medical Department of the U. S. Army. The President stated that it was his opinion that the creation of the new corps would not be in harmony with the present structure of the Medical Corps or the contemplated organization of the Medical Department of the postwar army.

Cleveland Heights—Dr. David Keating, member of the Board of Directors of the Academy of Medicine of Cleveland, spoke on "The Wagner-Murray-Dingell Bill" at a meeting of the Heights Kiwanis Club on April 23.

Middletown—Dr. Walter A. Reese, Middletown physician who served in the ETO for two years while in the armed forces, was principal speaker at the meeting of the Lions Club April 11. Speaking about his observations in Europe, he referred especially to the medical situation brought about by socialized medicine in certain European countries, and warned the club members against any Federal legislation which might take medicine out of the hands of private physicians.

Parade of Witnesses on W-M-D Bill Continues; Committee Takes Short Recess; Hearings May Continue into June

AFTER listening to testimony for and against S. 1606, the Wagner-Murray-Dingell bill, over a period of six weeks, the Senate Committee on Education and Labor announced a recess of two weeks on May 7, further consideration of the measure was to be resumed during the week of May 20.

In addition to the list of proponents published in the May issue of *The Journal*, the following representatives of welfare agencies, labor unions, and government departments have appeared before the Committee to urge passage of the bill:

Dr. Fred Mott, medical director, Farm Security Administration

Dr. Harold Aaron, medical advisor, Consumer's Union

Dr. Alice Hamilton, president, National Consumers League

James G. Patton, president, National Farmers Union

Charles G. Bolté, American Veterans Committee

James B. Carey, secretary-treasurer, C.I.O.

Lewis B. Schwellenbach, Secretary of Labor

Charles Brannan, Assistant Secretary of Agriculture

Martin Miller of the Brotherhood of Railroad Trainmen

Maurice Kaufman, D.D.S., and Seymour Shoenfeld, D.D.S., Dentists Committee for the Passage of the Wagner-Murray-Dingell bill

Dr. John Peters of Yale University School of Medicine, and Secretary of the Committee of Physicians for the Improvement of Medical Care

Mrs. Beatrice Jacobs, League of Women Shoppers

WANT PEPPER BILL ENACTED

Provisions of the bill regarding child and maternal welfare were endorsed by the following, many of whom urged further liberalization of these provisions by the substitution of the Pepper Bill, S. 1318:

Dr. Martha Eliot, U. S. Children's Bureau

Dr. Henry F. Helmholtz, chief of the Department of Pediatrics, Mayo Clinic

Dr. T. D. Jones, president, Rheumatic Fever Council of the American Heart Association

Mrs. Theodore Oxholm, Children Inc.

Hazel Corbin, R. N., general director, Maternity Center Association, New York City

Leonard W. Mayo, Cleveland, president, Child Welfare League

OPPOSITION SPEAKERS

Opposition to the Wagner-Murray-Dingell bill was expressed by:

Carl O. Flagstad, D.D.S., chairman of the Legislative Committee, American Dental Association

Mrs. Charles Sewell, administrative director, American Farm Bureau Federation

Fred Bailey, legislative counsel, National Grange

Rev. Raymond McGowan, National Catholic Welfare Conference

John H. Hayes, president-elect, American Hospital Association

Rev. Alphonse J. Schwitalla, president, Catholic Hospital Association

Rev. John Martin, past-president, Protestant Hospital Association

Rt. Rev. Msgr. John O'Grady, secretary, National Conference of Catholic Charities

Congressman A. L. Miller, M.D., Nebraska

Edward Poss, Grand Worthy President of the Fraternal Order of Eagles, told the Committee his organization favors a compulsory health insurance program but insists on maintaining the present independence of the medical profession. He suggested that the government should provide cash benefits to the patients with which they would pay for their medical care. In the course of his testimony he stated that despite the fact that free medical service is one of the benefits of membership in the Eagles, 85 per cent of the members seek the services of their personal physician when ill.

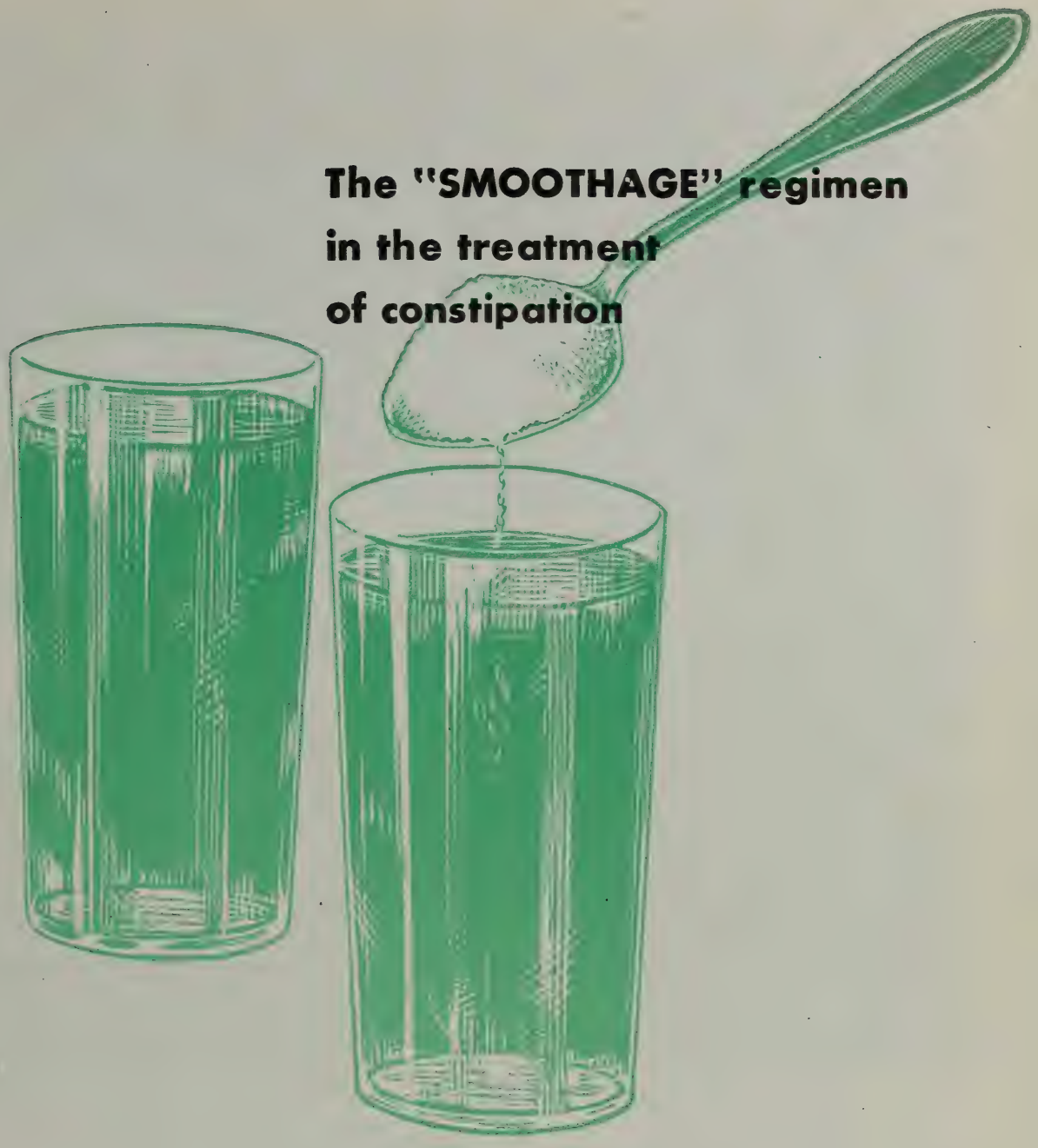
GENERAL BRADLEY TESTIFIES

General Omar N. Bradley, Administrator of Veterans Affairs outlined the V. A. program for medical care of veterans. He said that he was not prepared to discuss the provisions of S. 1606, but pointed out that under its provisions many veterans would have to pay additional taxes and still would not need many of the benefits.

Katharine J. Densford, president of the American Nurses' Association, presented a statement in which she stated that her organization had not had an annual meeting since the bill was introduced and therefore, she was in no position to express her organization's views.

An opportunity to appear before the Committee has been requested by a number of other groups including the American Academy of Pediatrics, and representatives of osteopaths, chiropractors, and undertakers.

The "SMOOTHAGE" regimen in the treatment of constipation



A rounded teaspoonful of Metamucil stirred into a glass of water, milk or fruit juice, three times a day, provides the soft, mucilaginous bulk which is desirable for natural elimination. Metamucil contains no roughage, no oils, no chemical irritants.

Metamucil is the highly purified, nonirritating extract of the seed of the psyllium, Plantago ovata (50%), combined with anhydrous dextrose (50%). It mixes readily with liquids, is palatable, easy to take.

Supplied in 1-lb., 8-oz. and 4-oz. containers.

Metamucil is the registered trademark of G.D Searle & Co.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

Infantile Paralysis Preparedness Conference for Doctors, Health Workers, etc., Scheduled for June 13-14, Columbus

IN anticipation of a possible infantile paralysis outbreak in Ohio this summer, the State Department of Health and the National Foundation for Infantile Paralysis are sponsoring an Epidemic Preparedness Conference to be held Thursday and Friday, June 13 and 14, at the Neil House, Columbus.

One of a series being held in various parts of the country, the meeting will hear national and state authorities on epidemiology, progress in research, pediatrics, treatment and care, hospitalization and public health problems.

Invited to the opening session beginning at 1:30 P.M., Thursday, are physicians, public health commissioners, hospital administrators, nurses and physical therapists. All physicians of the state are welcome.

Second day sessions, beginning at 9:00 A.M. and continuing through a luncheon, will be devoted to National Foundation chapter representatives and lay groups interested in public health.

The program for both days is as follows:

Thursday, June 13, 1946

Presiding: Dr. Charles Doan, Dean, School of Medicine, Ohio State University, Columbus

1:00 P.M.—Registration

1:30 P.M.—Afternoon Session

Dr. John Toomey—Professor of Pediatrics, Western Reserve School of Medicine, Cleveland
"Pediatric Considerations in the Care for Poliomyelitis Patients"

Dr. E. Harlan Wilson—Professor of Orthopedic Surgery, Ohio State University, Columbus
"The Evolution of Treatment of Poliomyelitis"

Dr. Shelby J. Gamble—Director, Department of Physical Medicine, Ohio State University, Columbus
"Treatment and the Results of Treatment"

Dr. Roger Heering—Director of Health in Ohio
"The Functions of a State Health Department in the Control of Poliomyelitis"

Mr. Robert Porter—Superintendent, Children's Hospital, Columbus
"Problems of Hospitalization for Acute Cases"

6:30 P.M.—Dinner Session

Dr. Thomas Francis, Jr.—Professor and Chairman, Department of Epidemiology, School of Public Health, University of Michigan, Ann Arbor
"A Report on the Progress of Polio Research"

Dr. Joseph G. Molner—Deputy Health Commissioner, City of Detroit, and Medical Consultant, National Foundation of Infantile Paralysis, Inc.
"The Role of the Foundation in State-Wide Epidemics"

Friday, June 14, 1946

Presiding: Daniel W. DeHayes, Ohio Representative, National Foundation for Infantile Paralysis, Inc.

9:30 A.M.—Registration

10:00 A.M.—Morning Session

Mr. Sid R. Phillips—Chairman, Franklin County Chapter, Columbus
"Greetings"

Dr. Roger Heering—Director of Health in Ohio
"The Functions of a State Health Department in the Control of Poliomyelitis"

Mr. Robert Canary—Assistant Chief, Division of Social Administration, State Department of Public Welfare
"Crippled Children Services Program in Ohio"

Mr. Donald E. Lea—District Supervisor, Bureau of Vocational Rehabilitation
"Vocational Rehabilitation in Ohio"

Mr. Louis C. Haughey—Assistant Treasurer and Comptroller, National Foundation for Infantile Paralysis, Inc., New York City
"Financial Problems in an Epidemic Situation"

12:30 P.M.—Luncheon Session

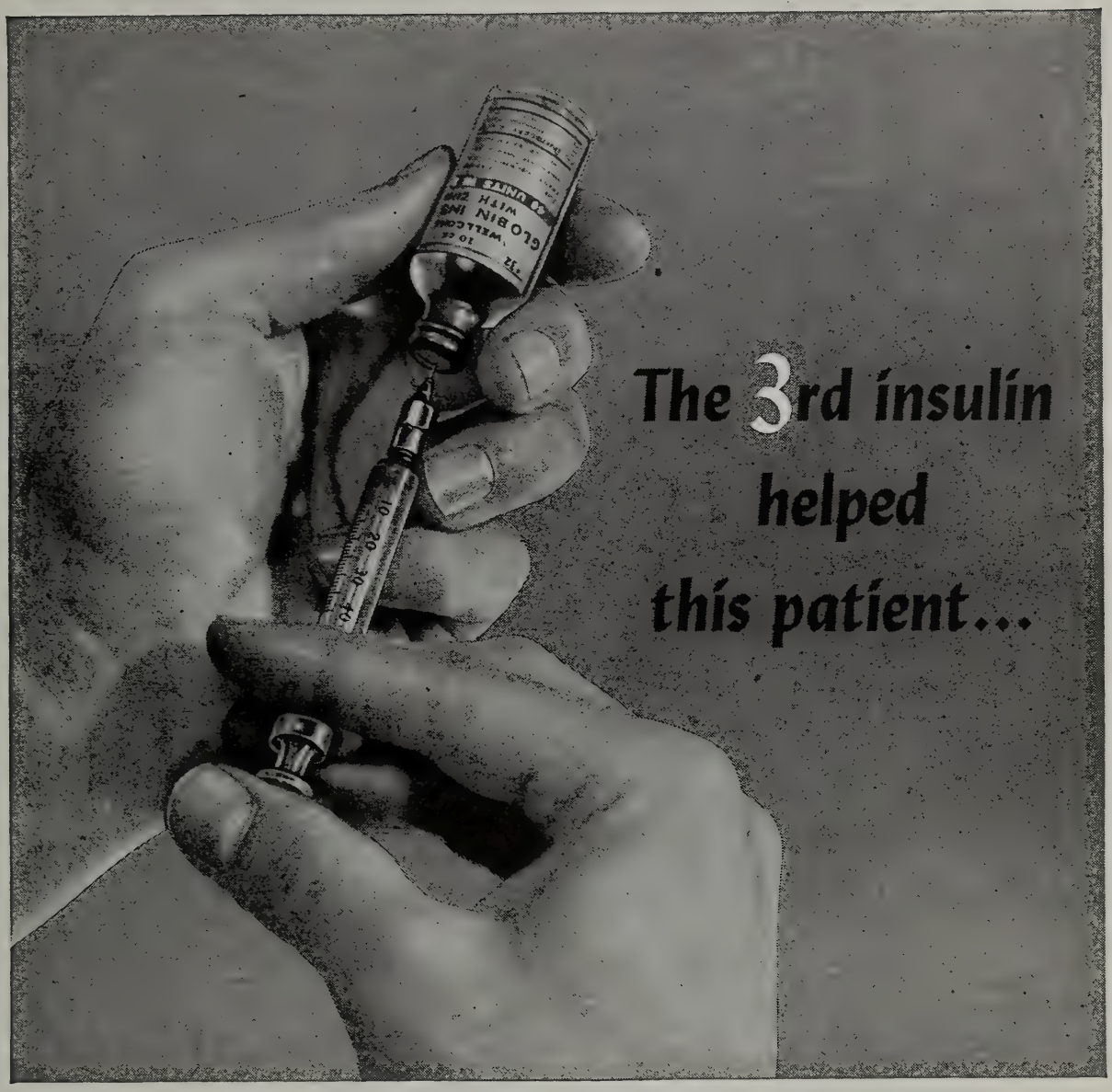
Dr. Thomas Francis, Jr.—Professor and Chairman, Department of Epidemiology, School of Public Health, University of Michigan, Ann Arbor
"A Report on the Progress of Polio Research"

Dr. Joseph G. Molner—Deputy Health Commissioner, City of Detroit, and Medical Consultant, National Foundation for Infantile Paralysis, Inc.
"The Role of the Foundation in State-Wide Epidemics"

Mrs. Justin A. Rollman—Ohio State Advisor on Women's Activities, Cincinnati, Ohio, National Foundation for Infantile Paralysis, Inc.
"Organization Plans for a Women's Division in Ohio"

Miss Elaine Whitelaw—National Director of Women's Activities, New York, National Foundation for Infantile Paralysis, Inc.
"The Function of the Women's Division in the Event of an Epidemic"

3:00 P.M.—Visit to Children's Hospital, Columbus, Mr. Robert Porter, Superintendent



TODAY, the physician treating diabetics, has the choice of three types of insulin. One insulin is rapid-acting but short-lived. Another is slow-acting but prolonged. Between them is the new 'Wellcome' Globin Insulin with Zinc, moderately prompt in starting, yet capable of sustained effect *for sixteen or more hours.* Such intermediate action is sufficient to cover the periods of maximum carbohydrate intake, and diminished enough by nighttime to minimize the likelihood of nocturnal reactions. Physicians do well to consider all *three* insulins when treating their diabetic patients.

'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its freedom from allergenic properties.

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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

A JOB WELL DONE UNDER ABNORMAL CONDITIONS

During the recent Centennial Anniversary Meeting of the Ohio State Medical Association, Columbus, Dr. L. Howard Schriver, Cincinnati, completed two consecutive terms as president of the Association, an expediency resulting from the war.

Only twice before in the 100-year history of the Association had a president been in office for two consecutive years.

The presidency of the Ohio State Medical Association is not an easy assignment. The responsibilities of the office and the demands on the time and energy of the incumbent are great. Actually, few members realize how many are the personal sacrifices which the president, as well as other members of The Council, must make to keep the machinery of the society grinding efficiently.

The past two years have been tough ones for those heading the activities of the Association. Unusually heavy commitments were required from the president and the other officials. The record shows that they handled their jobs well. Substantial progress toward many of the goals of the Association was made.

Although he would be the last to desire or expect it, Dr. Schriver deserves the appreciation of the membership of the Association for a job well done. With continuous leadership of the caliber he gave the Association, it can anticipate registering comparable records of real achievement during the ensuing years.

ONE REASON ENFORCEMENT OF MEDICAL ACT BREAKS DOWN

A municipal judge in Cincinnati in announcing the sentencing of an alleged chiropractor for practicing without an Ohio license, issued a statement to the press which indicated unfamiliarity with the Ohio Medical Practice Act or a misunderstanding of the purposes of that law.

In his statement, His Honor said that he had been giving chiropractors "the breaks" but he had to enforce the law, adding that he thought it strange that plumbers and other tradesmen were examined by boards of their own profession and granted licenses to practice.

Obviously, the judge fails to realize that all who profess to diagnose and to treat physical and mental illnesses are members of that general classification of persons engaged in the practice of the healing arts—namely, the practice of medicine under its broadest definition. Moreover, he apparently does not realize that anatomy is anatomy; chemistry is chemistry; pathology is pathology; bacteriology is bacteriology; etc., regardless of whether the applicant for a license is a chiropractor or a doctor of medicine and for this reason all applicants of all classes are given the same examinations in these basic subjects. Furthermore, he apparently does not know that members of the various branches are examined in their special field of practice by a a committee composed of those licensed in that particular field. Namely, chiropractors are examined in chiropractic subjects by chiropractors.

Building up excuses for those who violate the law of Ohio by practicing without a license—perhaps not even trying to obtain a license—lowers the dignity of the courts, in our opinion.

Here is an example why law enforcement breaks down. It also is an indication of the need for a closer relationship between the local medical society, law enforcement agencies, and the courts whereby the enforcement officers and jurists can be kept properly informed of provisions and purposes of the laws established to protect the health of the people.

THE BIG BRASS TOOTS A SOUR NOTE

Newsweek's Washington reporter offers the following humorous eye-opener about the bureaucrats' lobby:

> "Sen. Forrest C. Donnell last week revealed himself as an exorciser of ghost-writers, and Washington trembled at the threat to a comfortable tradition.
>
> "The Missourian opened his unorthodox attack as Secretary of Labor Lewis B. Schwellenbach concluded a twelve-page speech before the Senate Education and Labor Committee advocating passage of a health insurance bill. 'Who wrote that speech?' Donnell asked. When the Secretary hedged, Donnell charged that Schwellenbach, relying solely on his 'prestige as a member of the Cabinet', had made a speech on a subject 'he knows nothing about'. Despite Sen. Claude Pepper's protest that the Secretary was being questioned 'like a criminal', the attack continued.
>
> "Donnell: 'Has the Secretary read the testimony submitted by the Public Health Service to this committee?'
>
> "Schwellenbach: 'No.'
>
> "Donnell (reading from Schwellenbach's



HIGHLY EFFECTIVE . . .

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BECAUSE IT'S Conjugated

The high therapeutic effectiveness of "PREMARIN" by the oral route is due, in large measure, to the careful preservation of equine estrogens in the water soluble *conjugated form* in which all naturally occurring estrogens are excreted by the kidney.

By preventing hydrolysis which would destroy conjugation and convert equine estrogens to free chemical compounds (such as estrone), the highly desirable characteristics of the naturally occurring estrogens are retained . . . water solubility . . . oral activity.

To the physician . . . and the patient . . . this means that control of menopausal symptoms can be *established* as well as maintained by tablet or liquid medication.

"PREMARIN" is well tolerated and essentially safe. Treatment is usually followed by a general feeling of well-being.

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CONJUGATED ESTROGENS (equine)

Tablets of 1.25 mg. Tablets of 0.625 mg. Liquid, containing 0.625 mg. per teaspoonful

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speech): 'I am sure you all must have been impressed, as I have been, with the testimony submitted by the Public Health Service to your committee.'

"Schwellenbach (weakly): 'Your criticism is absolutely right.'"

Let that be a lesson to those who make speeches—know your subject; write your own speeches; don't try to fool the natives.

CONSOLIDATION MOVE A STEP IN RIGHT DIRECTION

President Truman's reorganization plan calls for abolishment of the Social Security Board and transfer of the health functions of the Children's Bureau, now in the Labor Department, to the office of Federal Security Administrator who also takes over the functions of the Social Security Board.

Whatever opinion one may have of some of the administrative personnel involved in this transfer of functions, it must be conceded that the change is a move in the right direction—namely, in the direction of consolidation of the health activities of the Federal Government under the same department.

Even with good leadership, the various far-flung boards, bureaus, and divisions dealing with health activities could not be expected to function efficiently under the old set up.

Under the revamping, the Federal Security Administrator will become even more powerful than at present. This means that he must be a man of capacity and sound judgment—something more than a political pawn and "yes" man. Mr. Watson B. Miller holds the office at present. We hope that he will demonstrate that he is big enough for the job.

IF THE G. I.'S CAN DO IT, SO CAN THE REST OF US

Mr. Richard M. Bourne, Cleveland, treasurer of the Ohio Division of the American Cancer Society, recently received the following letter from Captain John E. Wilson, Public Relations Officer of Camp Atterbury, Indiana, which, in our opinion, carried considerable significance:

"It is my privilege to transmit to you as Chairman of your Society the enclosed check in amount of $3,781.32 as a contribution from the separatees going thru this Separation Center during the month of April 1946.

"Circumstances connected with this contribution are as follows: A young Lieutenant whose name appears as custodian of the fund took it upon himself to place a jar in his department where the men were being given final payment for discharge. Announcements were made and the men dropped in a total sum of $7,271.78. Since these men represented many different states but principally the four states within the Fifth Service Command, we have seen fit to distribute this fund to the four states of Ohio, Indiana, Kentucky and West Virginia on a prorata basis figured on number of men from states indicated. According to our official figures 52 per cent of men discharged were from Ohio. We hope this distribution meets with your approval and that the fund may serve a worthy cause."

Apparently the G. I.'s, who have just fought one war, are prepared to help fight the war against cancer.

If the ex-service men are willing to shell out to the extent described above, certainly the public at large and the members of the medical profession should give their enthusiastic support to the educational and research activities of the American Cancer Society and other groups interested in this special field.

DEPENDS ON WHOSE OX IS BEING GORGED

Funny old world, isn't it?

Senator Murray and Senator Pepper, according to the papers, kinda think John Lewis's idea for a royalty on coal with which to create a miners' health-welfare fund, to be administered by him, sounds honkydory.

Yet, in the next breath, they snort with scorn about voluntary medical care plans and announce to the world that the almighty Federal government is only agency with enough brains to operate such a plan and that it ought to be compulsory.

MR. TRUMAN DOESN'T LIKE US, IT SEEMS

Have your ears been burning?

One Washington column says that President Truman's opinion of the opposition of the organized medical profession to his proposed national health program is "hardly printable".

This is really cheerful news amidst a pretty gloomy outlook which appears to have Mr. Truman buffaloed. When they get to the name-calling stage, it's a sign things don't seem to be going too well.

Keep pitchin', Brother!

BRITISH AND U. S ARMY REJECTIONS COMPARED

Those advocating government medical care insurance have used Selective Service rejections as propaganda to support their contentions. The finger of horror has been pointed to the fact that 30 per cent of all examined under the Selective Service Act were rejected.

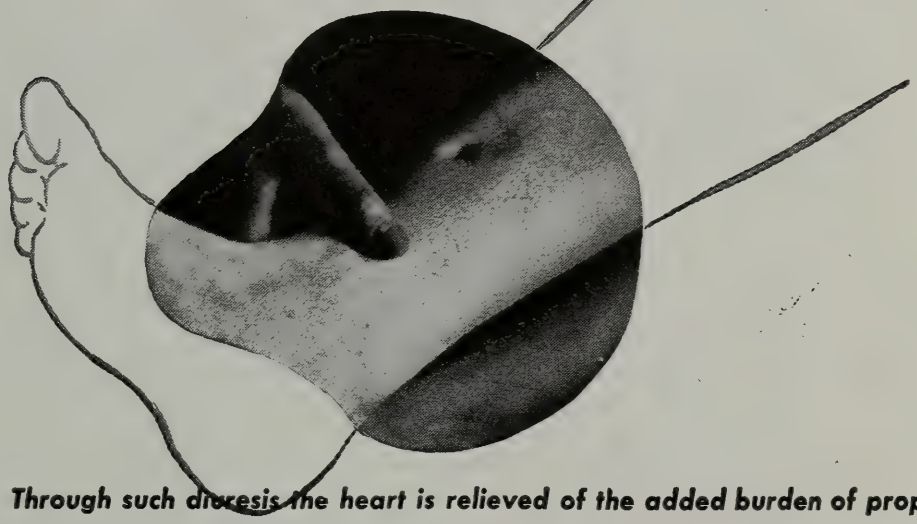
In our opinion statistics can be dug up to justify almost any side of any argument. However, wishing to get in the game, we cite as food for thought the British experience which appears to knock the arguments of the

For congestive heart failure:

NEXT IN IMPORTANCE TO DIGITALIS

In many cases of congestive heart failure mercurial diuretics are next in importance to digitalis in maintaining the patient's comfort and prolonging life.

Following an injection of Salyrgan-Theophylline in patients with marked edema the urinary output frequently amounts to three or four liters in twenty-four hours.



Through such diuresis the heart is relieved of the added burden of propelling the blood through the compressed blood vessels. The blood volume is decreased, and in all probability the efficiency of the heart is increased by elimination of myocardial edema.

•

Salyrgan-Theophylline is available in ampuls of 1 cc. and 2 cc. for intramuscular or intravenous administration . . . **For oral use** ***(as an adjunct to decrease the frequency of injections and when parenteral therapy is impracticable) tablets in bottles of 25, 100 and 500.***

SALYRGAN-THEOPHYLLINE

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"Salyrgan" trademark Reg. U. S. Pat. Off. & Canada
Brand of Mersalyl and Theophylline

potent mercurial diuretic

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proponents of compulsory medical insurance in the United States into a cocked hat.

Great Britain has had compulsory sickness insurance since 1911. According to a recent report on the British Army, rejections of those applying for enlistment for a 10-year period ran 59 per cent.

All of which would seem to show that rejections run parallel to living standards and that sickness insurance will not overcome that basic obstacle to a healthful population.

Army Lowers Discharge Requirements For Some Medical Officers

The Surgeon General of the Army has announced that discharge requirements for Medical Corps general duty officers were reduced on May 1 from 39 to 30 months service and for certain specialist officers from 43 to 39 months. Requirement on points remains at 60 and the age limit at 45 years.

This move will result in the discharge of approximately 2,000 doctors and will leave about 3,000 Medical Corps officers not included in the ranks of the Regular Army, volunteers and Army Specialized Training Program graduates.

Officers returning from overseas will be discharged automatically if they would become eligible for discharge within the following six months instead of four months as previously stipulated. Also, Army doctors overseas, regardless of their military occupational specialty classification, will be separated or en route to the United States within 60 days of date of eligibility.

Since VE Day about 32,000 medical officers have been discharged. The specialists who require the longer term of service for discharge are gastro-enterologists, cardiologists, urologists, dermatologists, anaesthetists, general surgeons, physical therapists, radiologists, pathologists, orthopedic surgeons, internal medicine specialists, and eye, ear, and nose specialists.

Reserve Officers on active duty with the Public Health Service who accumulated 38 or more points as of September 30, 1945, will be released from active duty by June 1, 1946. At monthly intervals thereafter, officers with totals of 34, 30, and 10 will be returned to civilian life. Points did not accumulate after September 30, 1945.

Oakwood—Dr. Roy D. Arn, has been appointed to the board of health to fill the unexpired term of Dr. Eleanor S. Everhard, who died recently. Dr. Arn was recently discharged from the Army Medical Corps with rank of colonel.

Youngstown—The Kiwanis Club awarded a gold pin to Dr. W. W. Ryall, former city health commissioner, in recognition of his 50 years of service in the community.

WOMAN'S AUXILIARY NEWS

BY MRS. FRED W. BROSIUS, MIDDLETOWN
Chairman, Publicity Committee

BELMONT

The Belmont County Medical Auxiliary held its April meeting at Belmont Hills Country Club, with the auxiliary of Ohio County, West Virginia, as guests.

Following luncheon and a brief business session, a bridge party was enjoyed by the members. Mrs. C. J. Holly, Bridgeport, is president of the auxiliary and was chosen as delegate to the State Auxiliary meeting in Columbus. Mrs. B. C. Diefenbach, Martins Ferry, was named alternate. Reported by Mrs. H. G. Harris, Martins Ferry, publicity chairman.

HAMILTON

The Woman's Auxiliary to the Hamilton County Medical Society held a board meeting May 17.

On May 27, a luncheon was held at the home of Mrs. Parke Smith, Cincinnati, for incoming and outgoing board members.

A Dessert Bridge, given in April at the home of Mrs. Gerald Castle, Cincinnati, president of the auxiliary, was an overwhelming success. The afternoon was spent in playing cards, awarding various prizes, and enjoying the delicious dessert which Mrs. Arthur Beyer, Cincinnati, and her committee had prepared.

About $300 was raised for the auxiliary's educational fund, proving that the affair was a financial as well as a social success. Many servicemen's wives were there and old and new friendships enjoyed. Mrs. A. G. Carmel, Cincinnati, is publicity chairman.

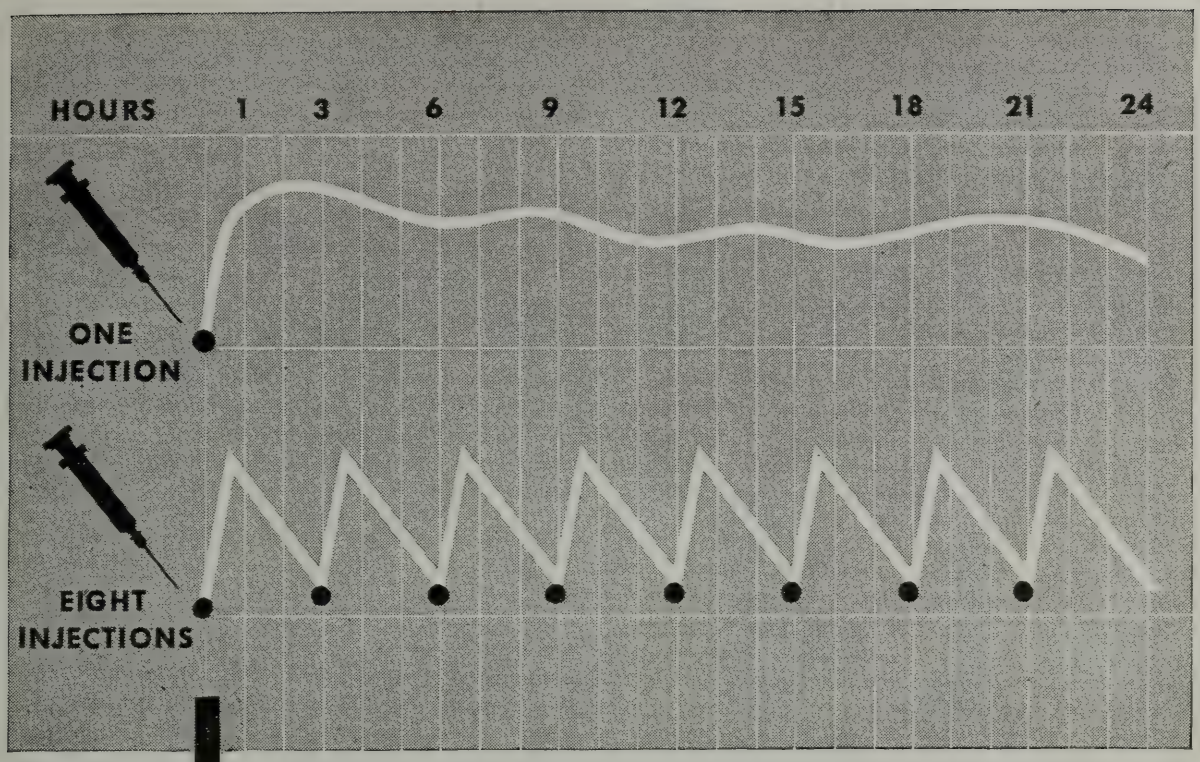
KNOX

The April meeting of the Woman's Auxiliary to the Knox County Medical Society met at the home of Mrs. Raymond Lord of Fredericktown. Eleven members were present. Mrs. John Drake, Mt. Vernon, president, conducted the business session.

The following officers were elected for the year 1946-47: president, Mrs. Charles Tramont, Mt. Vernon; vice-president, Mrs. Charles Baldwin, Centerburg; secretary-treasurer, Mrs. John Baube, Mt. Vernon.

At the close of the business meeting, Mrs. Lord gave a talk on Persian rugs and displayed several which Dr. Lord secured when he was stationed in Iran with the medical corps.

Refreshments were served at a table decorated with flowers and tapers. Mrs. E. V. Ackerman, Fredericktown, assisted as co-hostess. A luncheon at the country club will conclude the activities this year. Reported by Mrs. Julius Shamansky, Mt. Vernon, publicity chairman.



MAINTAIN HIGH PENICILLIN TIDE IN THE BLOOD STREAM BY ONE INJECTION IN 24 HOURS WITH ROMANSKY FORMULA

. . . OFFERED BY BRISTOL LABORATORIES

Office or home treatment now becomes practicable through administration of Penicillin in Oil and Wax as developed by Captain M. J. Romansky (M.C.) at the Walter Reed General Hospital, Washington, D. C. With this preparation it is possible to hold a penicillin therapeutic blood level by one injection in 24 hours, thus replacing the previous use of 8 injections of penicillin in saline over 24 hours.

There is usually less discomfort to the patient, and hence better cooperation. Also, by eliminating repeated injections the cost of treatment to the patient is lowered, and there is an appreciable saving in physicians' and nurses' time. This can be readily attained by the single injection of 1 cc. of 300,000 units in the oil-beeswax medium—known as Romansky formula, Bristol.

Bristol Laboratories now offer the Romansky formula with calcium penicillin. Due to special processing, the Bristol preparation is especially easy to inject. Write for new literature.

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In Memoriam

Wilbur Lee Ashton, M.D., Melbourne, Florida; Ohio State University College of Medicine, 1921; aged 49; died Apr. 16; former member of the Ohio State Medical Association and Fellow of the American Medical Association. Dr. Ashton formerly practiced medicine in Reynoldsburg. Surviving are his widow, a son, three daughters, and his mother.

George W. Beeghly, M. D., Dayton; Medical College of Ohio, Cincinnati, 1898; aged 84; died Apr. 29; former member of the Ohio State Medical Association and the American Medical Association. Dr. Beeghly practiced medicine for 46 years in Dayton, until his retirement two years ago.

Ella Grace Hunt, M.D., Cincinnati; Hahnemann Medical College and Hospital, Chicago, 1893; aged 78; died Apr. 14. Dr. Hunt had practiced medicine in Cincinnati until 1940. A sister survives.

James Thomas Lawless, Jr., M.D., Toledo; Toledo Medical College, 1901; aged 71; died May 2. Dr. Lawless was a medical officer in World War I, and was a member of the Catholic Knights of America. Surviving are his widow, a son, a daughter, three brothers, and a sister.

Clyde John Loveless, M.D., Granville; Ohio Medical University, Columbus, 1902; aged 75; died May 6; member of the Ohio State Medical Association and the American Medical Association. Dr. Loveless was serving his fourth term as mayor of Granville at the time of his death. He was vice-president of the Licking County Medical Society in 1919, and president in 1920. He was an examining officer for the selective service boards in both world wars; county health commissioner in the 1920's; member of the Methodist Church, American Legion, Masonic Lodge, Knights of Pythias; vice president of the Peoples State Bank of Granville; and a member of the Granville Library Board. He had practiced for 44 years. A son survives.

John Mohr, M.D., Cleveland; Western Reserve University School of Medicine, 1902; aged 75; died May 7. Dr. Mohr was a map maker as well as a physician. During the recent war, he was an examining physician for the General Motors Corporation. He was a member of the Masonic Order.

Thomas Marlett Moore, M.D., Willoughby; University of Wooster Medical Department, Cleveland, 1878; aged 89; died May 5; former member of the Ohio State Medical Association and American Medical Association. Dr. Moore had practiced medicine in Lake County for 68 years. He was a former president of the Lake County Medical Society. Dr. Moore's father and his grandfather were also Ohio physicians. His widow, a son, and two daughters survive.

William D. Murphy, M.D., Columbus; Ohio Medical University, Columbus, 1896; aged 76; died May 12; member of the Ohio State Medical Association and the American Medical Association. Dr. Murphy, who had practiced medicine in Columbus for 50 years, was vice-president of the Columbus Academy of Medicine in 1922. He was a member of the Masonic Lodge; a past potentate of Aladdin Temple; secretary of the Temple's Crippled Children's Association; member of the national Shrine's Crippled Children's Association, and the First United Presbyterian Church. He is survived by two sons. Dr. Link M. Murphy, Columbus, is a nephew.

Lister Pomerene, M.D., Coshocton; Kentucky School of Medicine, Louisville, 1891; former member of the Ohio State Medical Association and American Medical Association. Dr. Pomerene came to Coshocton from Holmes County in 1905. Surviving are his widow, a sister, and a brother, Dr. M. B. Pomerene, Millersburg.

William T. Scott, M.D., Martinsville; Medical College of Ohio, Cincinnati, 1889; aged 80; died Apr. 28; member of the Ohio State Medical Association and the American Medical Association. Dr. Scott had been a physician in Martinsville for 55 years. He was a member of the Masonic Lodge and Modern Woodmen of America. His widow survives.

Charles Edgar Turner, M.D., Columbus; Starling Medical College, Columbus, 1896; aged 72; died Apr. 22; member of the Ohio State Medical Association; Fellow of the American Medical Association; and Fellow of the American College of Surgeons. Dr. Turner served on the staff of Mt. Carmel Hospital, Columbus, for 50 years, and at the time of his death was a member of the board of directors and chief of staff of the department of obstetrics. He was a member of the Columbus Club. His widow survives.

Harvey Ray Wynn, M.D., Findlay; University of Michigan Homeopathic Medical School, Ann Arbor, 1912; aged 57; died Apr. 13; member of the Ohio State Medical Association and the American Medical Association; Fellow of the American College of Surgeons. Dr. Wynn was chairman of the Hancock County Medical Society's legislative committee from 1929 through 1934. During World War I he served as an officer of the Navy Medical Corps. He was a member of the Masonic Lodge, Methodist Church, and the Modern Woodman. His widow, a daughter, and a sister survive.



"Safe at third!" But that arm doesn't feel safe -- it hurts! So with complete confidence, Larry turns for help to his life-long friend, his family's physician. With equal confidence, physicians rely on Warren-Teed ethical pharmaceuticals for therapeutic performance.

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Data Received by The Journal Show 113 Additional Ohio Physicians Have Been Separated from the Service

INFORMATION has been received by The Journal showing an additional 113 Ohio physicians have been discharged from military service or have started terminal leave.

The following tabulation lists the names of these physicians, showing the city in which the physician resided or practiced prior to entering the service or the place of his relocation if he has relocated. The rank shown is based on the latest information on file with the State Association. It may not be up to date in some instances.

Name	City	Rank
Adelman, Jack A.	San Antonio, Tex. (formerly of Columbus)	Major, A.U.S.
Arapakis, P. Z.	Akron	Capt., A.U.S.
Ayres, Perry R.	Cleveland	Lt., U.S.N.R.
Bachman, Henry	Delaware	Capt., A.U.S.
Bakody, John T.	Des Moines, Iowa (formerly of Columbus)	Lt. Comdr., U.S.N.R.
Baurichter, F. Paul	Cincinnati	Lt. Comdr., U.S.N.R.
Bavor, Herbert J.	Brecksville (formerly of Berea)	Capt., A.U.S.
Beery, Wm. R.	Columbus	Capt., A.U.S.
Bliss, Theodore L.	Akron	Col., A.U.S.
Bone, James R.	Cincinnati	Capt., A.U.S.
Bonnot, Bernard R.	Canton	Lt. Comdr., U.S.N.R.
Borelli, John F.	Hamilton	Lt. Col., A.U.S.
Bossert, Lester J.	Cincinnati	Lt. Comdr., U.S.N.R.
Boucher, Howard E.	Columbus	Col., A.U.S.
Breckenridge, R. A.	Akron	Major, A.U.S.
Castle, Charles A.	Cincinnati	Lt. Comdr., U.S.N.R.
Clark, Thomas E.	Columbus	Lt. (jg), U.S.N.R.
Collins, James R.	Cleveland	Capt., A.U.S.
Craddock, William H.	Cincinnati	Lt. Col., A.U.S.
Cragg, Nelson R.	Cincinnati	Capt., A.U.S.
Craig, Robert M.	Dayton	P.A.S., U.S.P.H.S.
Crocker, David	Cleveland	1st Lt., A.U.S.
Crum, Louis J.	Cincinnati	Capt., A.U.S.
Cushing, Edward H.	Cleveland	Capt., U.S.N.R.
Dickey, Lincoln	Cleveland	Capt., A.U.S.
Doran, Patric C.	Akron	Major, A.U.S.
Dreyfuss, William	Cleveland	Major, A.U.S.
Edwards, Charles W.	Columbus	Major, A.U.S.
Elliott, William S.	East Palestine	Major, A.U.S.
English, Robert J.	Toledo	1st Lt., A.U.S.
Ferreri, Eugene A.	Cleveland	Capt., A.U.S.
Fidelholtz, J. N.	Toledo	Capt., A.U.S.
Fine, Archie	Cincinnati	Major, A.U.S.
Geiger, Franklin R.	Cincinnati	Major, A.U.S.
Gendelman, Samuel	Manchester	Capt., A.U.S.
Geroch, Stephen V.	Akron	Major, A.U.S.
Goldberg, Morris	Cincinnati (formerly of Columbus)	Capt., A.U.S.
Goldblatt, Samuel	Cincinnati	Major, A.U.S.
Grollman, Aaron I.	Cincinnati	Comdr., U.S.N.R.
Grossman, Royal G.	Cleveland	Col., A.U.S.
Hahn, Carl W.	Cleveland	Capt., A.U.S.
Halter, Paul E.	Cleveland	Lt., U.S.C.G.
Harris, Edward W.	Columbus	Major, A.U.S.
Hawk, Alpha F.	Melbourne Beach, Fla. (formerly of Urbana)	Major, A.U.S.
Haynes, Ormond L.	Richmond, Va. (formerly of Marietta)	Capt., A.U.S.
Herbert, Thomas J.	Portsmouth	Major, A.U.S.
Higgins, Kenneth E.	Cincinnati	1st Lt., A.U.S.
Hillabrand, John F.	Toledo	Lt. Comdr., U.S.N.R.
Howard, Kenneth R.	Toledo	Lt. Col., A.U.S.
Howland, Bernard U.	Portsmouth	Capt., A.U.S.
Hyman, Morris	Cincinnati	Major, A.U.S.
Joice, Joseph E., Jr.	Warren	Major, A.U.S.
Kirk, Robert C.	Columbus	Lt. Col., A.U.S.
Larsen, B. B.	Cleveland	Lt. Col., A.U.S.
Laughbaum, Thurman R.	Marysville (formerly of Galion)	P.A.S., U.S.P.H.S.
Lawrence, H. W.	Cleveland	Lt. Col., A.U.S.
Leider, Louis E.	Cleveland	Lt. Col., A.U.S.
Linn, George G.	Cleveland	Lt. Comdr., U.S.N.R.
Mabee, Horace G.	Lyndhurst	Major, A.U.S.
Malmud, Morris M.	Sharon Center	Major, A.U.S.
Maple, John L.	Louisville	Capt., A.U.S.
Martz, Raymond W.	Hamilton	Capt., A.U.S.
Matthews, Charles W.	Columbus	Major, A.U.S.
McCoy, States D.	Columbus	Col., A.U.S.
Miller, Ralph H.	Cincinnati	Major, A.U.S.
Moore, Randolph P.	Cleveland	1st Lt., A.U.S.
Morton, Wallace	Toledo	Major, A.U.S.
Nenninger, John R.	Cincinnati	Lt. Comdr., U.S.N.R.
Newell, Thomas E.	Dayton	Comdr., U.S.N.R.
Peck, Howard B.	Mansfield	Lt. Col., A.U.S.
Pickard, Edgar C.	Cuyahoga Falls	Lt. Col., A.U.S.
Porter, William L.	Cincinnati	Major, A.U.S.
Ramsayer, Ralph K.	Canton	Lt. Col., A.U.S.
Rawers, Clarence B.	Bergholz	Capt., A.U.S.
Rankin, Thomas J.	San Diego, Calif. (formerly of Oxford)	Lt. Col., A.U.S.
Reps, Dewey H.	Cincinnati	Major, A.U.S.
Rhodes, William M.	Columbus	1st Lt., A.U.S.
Rivers, Daniel C.	Cincinnati	Capt., A.U.S.
Roach, William L.	Cincinnati	Lt. Col., A.U.S.
Robinson, Harry H.	Cleveland	Major, A.U.S.
Rose, Donald E.	Silver Springs, Maryland (formerly of Dayton)	Major, A.U.S.
Rosenbaum, Joseph G.	North Royalton	Capt., A.U.S.
Rowland, Guy A.	Cleveland	Lt. Comdr., U.S.N.R.
Ruegsegger, James M.	Pearl River, N. Y. (formerly of Cincinnati)	Lt. Comdr., U.S.N.R.
Rusk, Ross P.	Cleveland (formerly of Cadiz)	Major, A.U.S.
Sachs, Edward W.	Dayton	Capt., A.U.S.
Sapadin, Albert	Cincinnati	Capt., A.U.S.
Scheib, Burton V.	Toledo	Lt., U.S.N.R.
Schmidt, John R.	Cincinnati	Lt. (jg), U.S.N.R.
Schneider, Bernard M.	Youngstown	Capt., A.U.S.
Schoene, Robert H.	Columbus	Capt., A.U.S.
Schroder, Charles R.	Cincinnati	Capt., A.U.S.
Schulze, A. Gordon	Amelia	Major, A.U.S.
Schwemlein, George X.	Cincinnati	P.A.S., U.S.P.H.S.
Skaggs, Marshall L.	Cincinnati	1st Lt., A.U.S.
Smith, Charles M.	Portsmouth	Comdr., U.S.N.R.
Smith, Frederick G.	Marion	Lt. Col., A.U.S.
Smith, John Joseph	Cleveland	1st Lt., A.U.S.
Smith, Simmons S.	Cleveland	1st Lt., A.U.S.
Snively, Lloyd M.	Massillon	Capt., A.U.S.
Statman, Solomon H.	Galveston, Texas (formerly of Cincinnati)	Lt. Col., A.U.S.
Steinberg, A. H.	Toledo	Capt., A.U.S.
Stempien, Stephen J.	Cleveland	Major, A.U.S.
Stimson, George A.	Ann Arbor, Michigan (formerly of Sandusky)	Comdr., U.S.N.R.
Taplits, Sol	Cincinnati	Major, A.U.S.
Thompson, John M.	Upper Sandusky	Major, A.U.S.
Vinnedge, William F.	Hamilton	Major, A.U.S.
Volzer, Elmer A.	Canton	Capt., A.U.S.
White, Charles A.	Cleveland	1st Lt., A.U.S.
Wilcox, John M., III	Paulsboro, N. J. (formerly of Cleveland)	Capt., A.U.S.
Wilson, Rex H.	Akron	Major, A.U.S.
Wylie, L. Burdett	Cleveland	Major, A.U.S.
Yauger, George W.	Cincinnati (formerly of Dayton)	Major, A.U.S.

Military News Notes

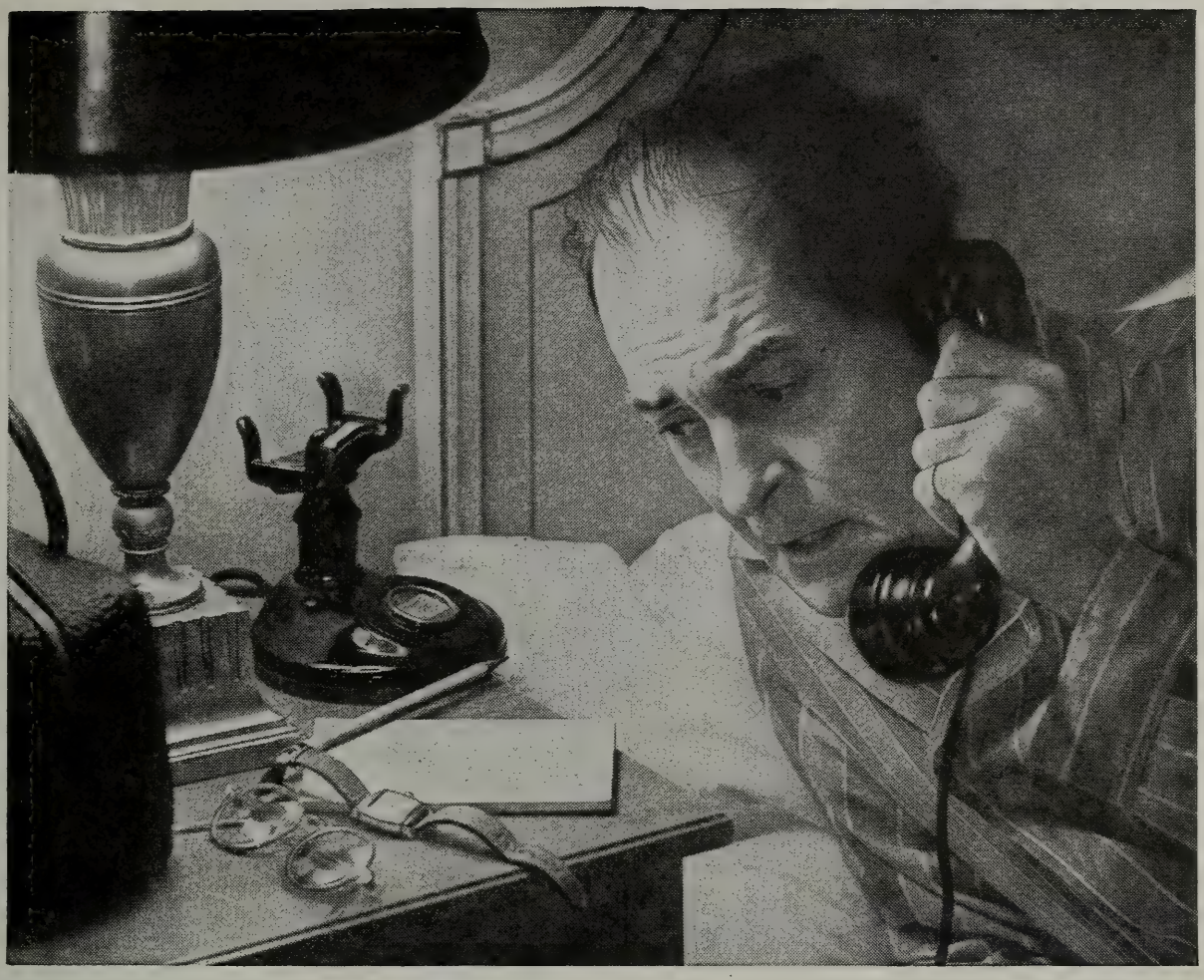
Capt. Garrett B. Ackerman, Columbus, with the medical detachment of the 51st M. P. Bn., in Korea, is hopeful that he will be back home early this summer.

* * *

Lt. Comdr. Joseph W. Colvin, Cincinnati, is head of the department of tropical medicine at the U. S. Naval Medical School, Bethesda, Md.

WIN PROMOTIONS

Name	City	Rank
Boldizar, Albert G.	Cleveland	Capt., A.U.S.
Calvin, Joseph W.	Cincinnati	Lt. Comdr., U.S.N.R.
Hill, Eugene Scott	Canton	Major, A.U.S.
Zodikoff, Rudolph M.	Cincinnati	Major, A.U.S.



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According to a recent independent nationwide survey:

More Doctors Smoke Camels

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R. J. Reynolds Tobacco Company, Winston-Salem, N. C.

Dr. J. A. Rogers, Youngstown, Wins Medical Golf Crown For 1946 at Scioto Course, Columbus, May 6

THE Ohio State Medical Golfers' Association after several years of hibernation made its appearance on the beautiful Scioto Country Club course, Columbus, on May 6, as a preliminary event of the Annual Meeting of the Ohio State Medical Association.

Overcast skies, intermittant drizzles, and cold winds failed to dampen the spirits of so virile a group of doctors. Nor did it mar the renewal of friendships—many of long standing.

Although the attendance, forty-nine golfers in all, was not as large as in some of the past tournaments, it was gratifying to those present to know that the Association had made a successful comeback and would again take its place as a famous "one day a year institution".

SHOOTS A 75

Dr. J. A. Rogers, Youngstown, a serious threat in past tournaments, again displayed his ability as a golfer by touring the difficult Scioto course in 75 strokes to win the Tournament Championship.

Dr. S. L. Vinci, Cleveland, off to a late start, came in a close second with a score of 79. This won for the former Ohio State University golfer, the Ohio State Medical Journal Trophy for the Junior Class. In the age group from 36 years to 45 years of age, Dr. J. P. Bolton, Columbus, took honors with a score of 81.

Dr. E. J. Wenaas, Youngstown, won the Buckeye Union Casualty Trophy for the age group 45 years to 55 years of age with a score of 86. In the next age group, 56 years to 65 years of age, Dr. A. K. Buell, Columbus, also scored an 86 to win this event. Dr. M. R. Kellum, Cleveland, with a score of 93 was awarded the Mills Restaurant Trophy for low score over 66 years of age.

SPECIAL EVENT WINNERS

Other winners in special events were Dr. P. C. Clark, Columbus, low number of putts, 28; nearest tee shot to pin on Hole 9, Dr. F. T. Gallagher, Lakewood; longest drive, Dr. E. M. Kaufman, Kent; putting contest, Dr. E. B. Young, Lima, with 31 strokes.

The S. J. Coulter Team Trophy went to the Columbus fivesome—composed of Drs. J. B. Bolton, P. C. Clark, A. N. Buell, W. B. Morrison, and C. M. Larrick with a total score of 425 as compared with the Cleveland Team's score of 427.

The local Committee under the direction of Dr. W. B. Morrison deserves a great deal of credit for making arrangements for this year's golf tournament.

NEW OFFICERS ELECTED

A short business meeting was called to order by President E. C. Yingling, Lima, after the last golfer had showered. The following nominations were made from the floor and unanimously elected to handle the 1947 Tournament: President, Dr. John W. Conwell, Cleveland; 1st Vice-President, Dr. Jerome Ziegler, Cincinnati; 2nd Vice-President, Dr. R. C. Young, Toledo; Secretary-Treasurer, Mr. Robert W. Elwell, Toledo. The Secretary was instructed to compile an accurate roster of interested Ohio Medical Golfers in order that proper notification can be sent regarding plans for next year's tournament. The motion was unanimously passed that dues of $1.00 be paid each year by those members playing in the tournament.

It is the hope of the newly elected officers that 1947 will see a large attendance and an evening banquet following the play.

The Association encourages any doctors who have not played in previous tournaments to drop a card to Secretary Elwell, care of the Academy of Medicine of Toledo, in order to be placed on the roster.

Trumbull County Auxiliary Sponsors A.M.A. Radio Series

Radio station WRRN, Warren, is broadcasting the series of radio transcriptions, "The Public Comes First", prepared by the Bureau of Health Education and the Council on Medical Service and Public Relations of the American Medical Association. The Warren program was arranged by Mrs. David L. Beers, president of the Woman's Auxiliary to the Trumbull County Medical Society.

In these transcriptions, Harriet Hester, nationally known radio script writer, interviews members of the Council concerning various phases of the medical care problem, urban and rural health, voluntary prepayment plans, and the A.M.A. constructive program for medical care. The series consists of six fifteen-minute transcriptions.

There is no charge for the transcriptions. The platters may be obtained by writing to the Bureau of Health Education, American Medical Association, 535 N. Dearborn St., Chicago, Ill.

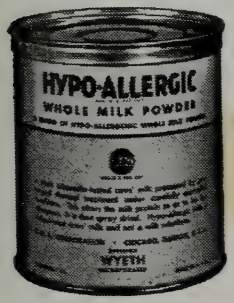
Broadcasts are usually scheduled by the radio stations on a sustaining (no fee) basis, as a public service, because of growing interest in the subjects presented.



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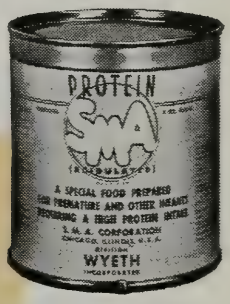


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WHOLE MILK

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POWDER—1 lb. tins **LIQUID 14½ oz. tins**

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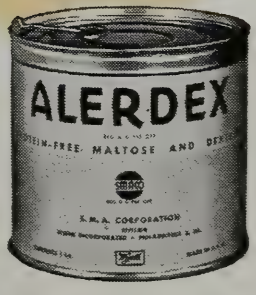


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(Acidulated)

The easily digested curd and liberal vitamin content makes Protein S-M-A a valuable aid in the management of premature and undernourished newborn infants. Also indicated in infant diarrhea and other conditions where a high protein intake is required.

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An all-around milk modifier especially useful in the hypo-allergenic milk diet of the infant sensitive to proteins, Alerdex is prepared from noncereal starch by a special procedure to eliminate every trace of protein.

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S. M. A. DIVISION

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VETERANS' INQUIRY DEPARTMENT

Ohio Openings and Locations Sought by Returning Medical Officers; Opportunities Available Listed

THE purpose of this department is to provide space without cost to Ohio veteran physicians for the publication of inquiries they may wish to make concerning an assistantship or residency, a partnership or space in an office, locations and purchase of a practice, purchase of equipment, etc.

The new feature also offers an opportunity for physicians who desire to dispose of their practice or institutions and agencies needing staff physicians to publicize this information for the benefit of service men.

The feature will appear monthly as long as there seems to be a need for it. The regulations governing it are: (1) The veteran submitting the inquiry must be an Ohio physician, i.e., one who was in practice in Ohio when he entered the service or was a native of Ohio but still in training when he entered in the service. (2) Inquiries should not exceed 35 words. (3) Copy must be submitted by the 20th day of the month preceding date of publication. (4) Unless otherwise specified, each inquiry will be carried in two consecutive issues of *The Journal* but no oftener. (5) *The Journal* reserves the right to reject or edit copy submitted; also, to eliminate the new department when and if conditions warrant. (6) Inquiries should be accompanied by full name, forwarding address and identifying data.

OPPORTUNITIES SOUGHT

PRACTICE WANTED: Veteran will buy practice of retiring or deceased physician, small city preferred. Ten years' practice before entering service. V.I.D. No. 11, care of Ohio State Medical Journal.

INDUSTRIAL OR INSURANCE POSITION WANTED: By discharged Army medical officer. Ten years in general practice. Over three years in service, mostly spent as administrative head of installation doing large number of physical examinations. Age 44. V.I.D. No. 12, care of Ohio State Medical Journal.

OPHTHALMOLOGY TRAINING SOUGHT: Training in ophthalmology through residency or assistantship wanted by discharged Army medical officer; ten months' eye work in Army; capable refractionist. Age 34. Graduate of Ohio State University College of Medicine. V.I.D. No. 13, care of Ohio State Medical Journal.

TRAINING IN OTOLARYNGOLOGY: Discharged Naval flight surgeon, with 62 months of military service, age 41, graduate of Ohio State University, desires post-graduate training in otolaryngology and refraction by means of residency or assistantship. V.I.D. No. 14, care of Ohio State Medical Journal.

ASSOCIATION SOUGHT: Discharged Navy medical officer, age 33, thorough training in internal medicine, especially cardiology, graduate of University of Cincinnati, desires association with established internist or group clinic. Will locate in small town in need of internist. Member of Cincinnati Academy of Medicine. V.I.D. No. 15, care of Ohio State Medical Journal.

INTERNIST SEEKS OPENING: Internist, with two and one-half years clinical training, completing American Board of Internal Medicine examinations, age 33, licensed in Ohio, desires association with group or well-established internist. Available after April 1, 1946. V.I.D. No. 16, care of Ohio State Medical Journal.

WANTS SURGICAL RESIDENCY: Veteran medical officer, age 36, with year's internship, year of general residency, two years of general practice and 57 months service in Army as battalion surgeon and 25 months with orthopedic section of general hospital, desires approved residency in general surgery. V.I.D. No. 17, care of Ohio State Medical Journal.

ASSOCIATE PRACTICE SOUGHT: Internist, age 31, graduate of University of Cincinnati College of Medicine, 1938, four years hospital training, including one year cardiac fellowship, eligible for certification by American board, desires association with internist or group. Available immediately. V.I.D. No. 18, care of Ohio State Medical Journal.

PRACTICE WANTED: Obstetrician and gynecologist, discharged medical officer, age 38, desires obstetrical and gynecological practice or association; eligible for American board. V.I.D. No. 19, care of Ohio State Medical Journal.

RESIDENCY DESIRED: A gynecological or surgical residency wanted by returning medical officer, age 42, with three and one-half years hospital training and 10 years general practice; available in March. V.I.D. No. 20, care of Ohio State Medical Journal.

ASSISTANTSHIP WANTED: Discharged Army medical officer desires assistantship with busy general practitioner. Graduate of Northwestern Medical School, 1940; one year rotating internship, Cincinnati General Hospital; special training and degrees in chemistry, physiology and gastroenterology; age 32; single. V.I.D. No. 21, care of Ohio State Medical Journal.

LOCUM TENENS DESIRED: Wanted for three months beginning September 15 by Navy medical officer who will begin residency January 1. Graduate of Harvard Medical School in 1944; aged 26; internship Lakeside Hospital, Cleveland. V.I.D. No. 22.

OPPORTUNITIES OFFERED

GENERAL PRACTICE AVAILABLE: Excellent opportunity immediately for young physician for heavy practice. No other physicians in town of 1,000, located in Northwestern Ohio, surrounded by rich agricultural area. Modern house and separate office available at low rental. Write S.P.C., care of Ohio State Medical Journal.

INTERNS AND HOUSEMEN NEEDED: Good Samaritan Hospital, Dayton, has openings for six interns. Internships approved by American Medical Association. Weekly seminars offered by members of various specialty boards. Also vacancies for four returning veterans as housemen; also entitled to seminars. Stipends for interns $50.00 with full maintenance; stipends for housemen, $150.00 with full maintenance. Contact Intern Committee of hospital.

OPENING FOR GENERAL PRACTICE: Opening in Toledo for young man interested in general practice (surgically inclined) to reopen a former well-established practice. Office completely furnished. Reason: Limiting practice to internal medicine. Excellent location for future group practice. D.O.M., care of Ohio State Medical Journal.

CLINIC STAFF OPENING: Opening for young man interested in general practice on staff of group clinic. Compensation first few months on salary basis; thereafter

on percentage basis. All equipment furnished by clinic. L.A.C. care of Ohio State Medical Journal.

PRACTICE AVAILABLE: Practice in Valley City, Medina County, 20 miles from Cleveland, in heart of thriving farming and dairy community, available. Physician who located there during war emergency, desires to return to special practice in city. House, with combined office available any time. Contact Dr. F. C. Reutter, Valley City, Ohio.

PART-TIME INDUSTRIAL PRACTICE: Good opening for physician interested in part-time industrial practice, physical examinations, and emergencies. Columbus industrial firm. Write C.W.C., care of the Ohio State Medical Journal.

INDUSTRIAL COMMISSION: Openings available in Medical Section, Ohio Industrial Commission. Consult Dr. Robert André, chief supervisor, Medical Section, State Office Bldg., Columbus.

STATE HOSPITAL STAFF OPENINGS: Staff physicians for various institutions serving the mentally ill, mentally defective and epileptic needed. Physicians who have had some psychiatric training or experience preferred but can offer positions to doctors who may be interested in becoming acquainted with the specialty. Two positions of special importance now open are: Superintendency, Youngstown Receiving Hospital (especially attractive for young physician with residency in psychiatry) and Clinical Directorship, Gallipolis State Institute (fine opportunity for man who has had neuropsychiatric training to become acquainted with those neurological conditions that cause epilepsy in addition to a chance to be a specialist in the field of true epilepsy). Consult Dr. Frank F. Tallman, Ohio Commissioner of Mental Hygiene, State Departments Building, Columbus 15.

PUBLIC HEALTH OFFICERS NEEDED: Several counties in Ohio in need of full-time health commissioners. Those with training and experience, or interested in public health work, may obtain complete details from Dr. Roger Heering, Ohio Director of Health, State Departments Building, Columbus 15.

PRACTICE FOR SALE: Active practice in a community of 3,000, North Central Ohio. Large amount of industrial work in addition to regular practice. Equipment includes new X-ray, diathermy, modern furniture, drugs and supplies. No real estate for sale. Moderate rent. Estimated price $7,500, cash or terms. Will introduce for a short time. Write R.J.S., care of Ohio State Medical Journal.

TUBERCULOSIS HOSPITAL OPENING: Resident physician needed in this institution doing intensive collapse therapy, including surgery. Good opening for man who desires to enter this field of medicine. District Tuberculosis Hospital, Lima; H. H. Brueckner, M.D., superintendent.

VETERANS ADMINISTRATION: Openings for physicians as members of rating boards for either full time or part time duty. Basic salary $4300.00 per annum, with additional compensation for overtime. Contact nearest V.A. office for particulars.

PRACTICE AVAILABLE: General practice at Friendship, Scioto County; seven miles from Portsmouth, which has two hospitals; population of area about 8,000; centralized elementary school; within six miles of High School; two Protestant churches; combined residence and office, with four-acre plot, available for sale or rent; no other physician in community. G.F.J., care of Ohio State Medical Journal.

FULL-TIME RESIDENT PHYSICIAN NEEDED: At Homeplace, Perry County, Kentucky, operated by E. O. Robinson Mountain Fund as educational center for mountain people. Graduate nurse; clinic building being planned; affiliation with medical center in Cincinnati for consultation and specialized services; salary $5,000 per year, with home and transportation furnished. Write Dr. Howard P. Fischbach, 1122 Carew Tower, Cincinnati 2, Ohio.

PRACTICE AND HOME FOR SALE: Active practice established 10 years in town of 2000 with local post office serving 8000. Brick and stone home with modern interior. Has suite of rooms for office. All modern office equipment with stock of drugs and X-ray, diathermy, ultraviolet. Seeing more than 20 patients per day. Physician urgently needed. Forced by service-connected disability to retire from general practice. All is offered to a veteran for price of real estate alone. Liberal terms; can pay for all in three years from earnings. M. R. Wedemeyer, M.D., Oak Hill, Ohio.



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Licenses Granted to 256 Doctors of Medicine by State Medical Board at Meeting in Columbus, May 7

LICENSES to practice medicine and surgery in Ohio were granted 256 graduates of approved schools of medicine who passed the March examinations, according to an announcement from the Ohio State Medical Board, which met May 7.

Dr. E. J. Clinger, Columbus, a graduate of the Ohio State Universty College of Medicine, made the highest grade, 90.2 per cent, in the medical examinations. Dr. J. A. Hagans, Cincinnati, a graduate of the University of Cincinnati College of Medicine, placed second with a grade of 89.4 per cent, while two graduates of the Western Reserve University School of Medicine, Dr. Robert J. Izant, Jr., Cleveland Heights, and Dr. Phillip Perloff, Cleveland, tied for third place with grades of 89.1 per cent.

A total of 14 graduates of osteopathic schools, who complied with the requirements, were successful, and will receive certificates to practice osteopathic medicine and surgery. In addition, in conformity with the new law, certificates to practice osteopathic medicine and surgery were granted 20 osteopaths, previously licensed to practice osteopathy and surgery. These certificates were granted on the basis of successful completion of additional examinations.

In the limited branches, certificates were awarded to one chiropractor; three mechanotherapists; nine cosmetic therapists; seven chiropodists, and 16 masseurs.

The following doctors of medicine were granted licenses:

OHIO STATE UNIVERSITY COLLEGE OF MEDICINE—Adams, Patricia V. O., Columbus; Bade, Paul H., Greensprings; Bennett, Albert R., Cleveland; Clapper, Henry H., Columbus; Clemente, Bartholomew, Akron: Clinger, Edwin J., Columbus; Davis, William M., Akron; Dawson, Katherine E., Columbus; Denton, Max E., Mt. Gilead; Dicken, Dorothy M., Oak Harbor.

Diley, Russell B., Pickerington; Dreisbach, John A., Columbus; Duggar, William O., Columbus; Elliott, Dean C., Westerville; Ervin, Herbert K., Columbus; Feigert, Marion W., Van Wert; Green, Jr., Thomas W., Columbus; Hadobas, Stephen L., Steubenville; Hales, Cecil W., Liberty Center; Hoeflinger, George R., Columbus; House, Willard E., Columbus; Jennings, Raymond L., Columbus.

Jividen, Charles F., Racine; Kane, Arnold L., Cleveland Heights; Kasmersky, Chester T., Columbus; Kaumeyer, William F., Lancaster; Kessler, Robert R., Columbus; Kosar, Joseph, Columbus; Krech, William J., Columbus; Kubbs, Francis W., Edison; Leimbach, Warren H., Vermilion; Levine, Albert H., Cleveland; Lilly, John S., London; McClave, Charles R., East Portsmouth.

McKitrick, Jr., Charles J., Cambridge; Meckstroth, Norman A., New Knoxville; Meltzer, Milton, Cleveland Heights; Merkle, Harlan B., Hartville; Miller, Morton L., Cleveland; Murphy, Robert J., Columbus; Newman, Jerry I., Canton; Pack, Jr., George T., Columbus; Paugh, John T., Youngstown; Phillips, Merle L., Columbus; Platt, Daniel E., Columbus; Pocock, Dean S., Lancaster.

Pratt, Joel F., Columbus; Ream, Donald L., Canton; Rimelspach, John J., Columbus; Rosenblum, Saul A., Dayton; Saslaw, Samuel, Cleveland; Schroer, George J., Coldwater; Siberd, Leopold W., Toledo; Skipton, Robert D., Marietta; Smilack, Ann, Columbus; Spyker, Thomas H., Plain City; Stahler, John C., Columbus; Startzman, John E., Columbus.

Steinberg, Donald, Toledo; Swanson, Gerald W., Columbus; Swoyer, Grover B., Pittsburgh, Pa.; Tallman, Claude A., Toledo; Vickery, Don L., Columbus; Volk, David, Cleveland; Warner, Marjorie L., Canal Zone; Watson, Jr., Clovis A., Canton; Wemmer, Keith S., Toledo; Wenzel, Richard L., Marietta; Whitacre, Victor C., Chesterhill.

Williams, James H., Columbus; Wilson, Richard R., Columbus; Winzeler, Ruth H., Bryan; Zartman, Edwin R., Columbus.

UNIVERSITY OF CINCINNATI COLLEGE OF MEDICINE—Anton, Anthony T., Springfield; Bedell, George N., Cincinnati; Blydenburgh, George D., Delaware; Bresher, Jerome T., Cincinnati; Britt, Robert L., West Lafayette, Ind.; Brown, Michael, Cincinnati; Carroll, Paul T., Columbus; Carson, Robert P., Wheelersburg; Corday, Robert J., Shaker Heights; Curtis, Bernard M., New York City; DiSalvo, Remo J., Cincinnati; Dornette, William H., Cincinnati.

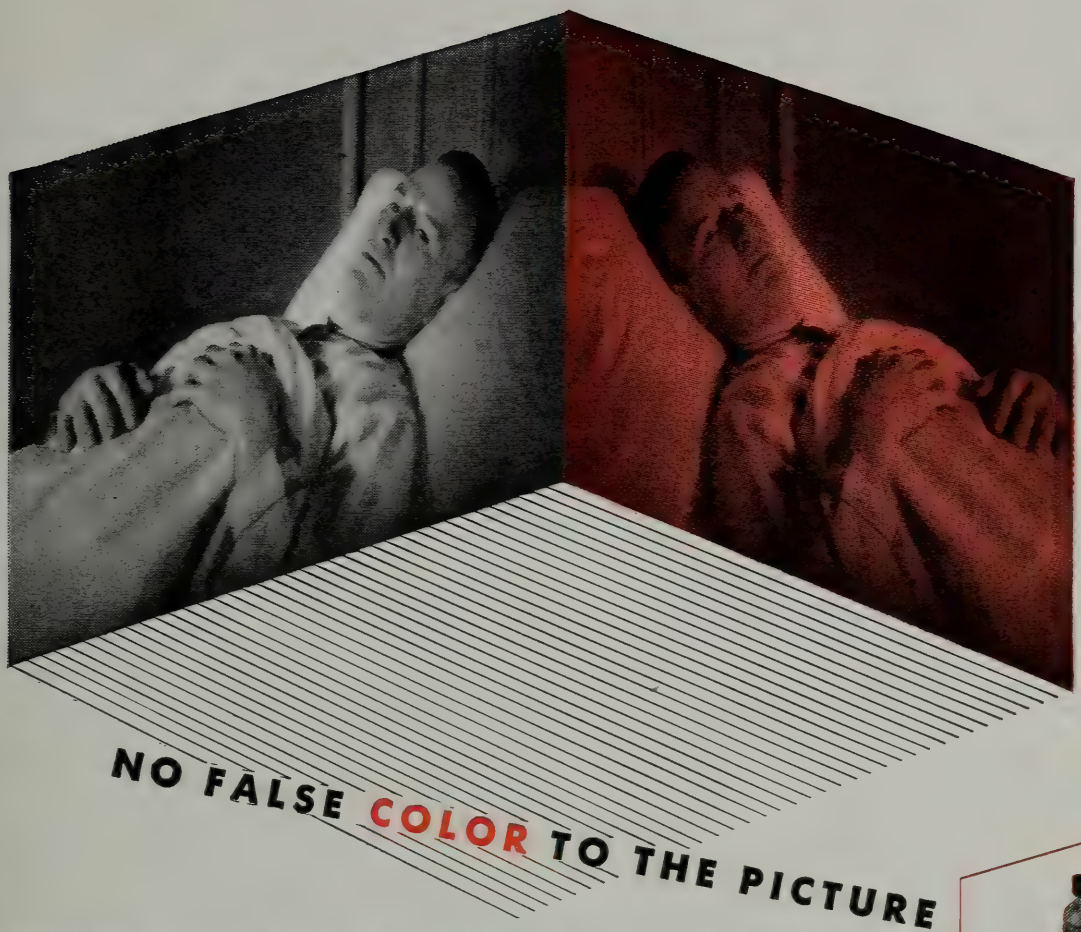
Fishman, Stanley I., Cincinnati; Flax, Harry, Cincinnati; Fleischman, Meyer J., Cincinnati; Franklin, Jr., John W., Chillicothe; Freese, Martin L., Lancaster; Golter, Lowell E., Cincinnati; Gray, Jr., Clell C., Long Beach, Calif.; Gressel, Gregory C., Hamilton; Hagans, James A., Cincinnati; Hagans, Mary Veder, Cincinnati; Hampshire, Alice L., Grand Rapids; Hartenian, Edward, Cincinnati; Hemmer, John A., So. Ft. Mitchell, Ky.

Hiatt, Harold, Wilmington; Hofling, Charles K., Cincinnati; Howes, Harriet B., Cincinnati; Hubbard, Richmond C., Cincinnati; Hugenberg, Janet B., Cincinnati; Kaplan, Stanley M., Cincinnati; Kelly, James J., Ludlow, Ky.; Klein, Jr., Harvey S., Huntington, W. Va.; Lewis, Hallett A., Cincinnati; MacMillan, James E., Cincinnati; Matthews, Florence K., Cleveland; McConnell, Betty G., Cincinnati.

McConnell, Robert W., Cincinnati; Meitus, Marvin L., Cincinnati; Moore, Ernest E., Butler, Pa.; Moore, Jr., Robert M., Indianapolis, Ind.; Morey, Gordon R., Cincinnati; Mueller, Elmer J., Cincinnati; Mueller, John F., Hamilton; Nagel, Joseph F., Bronx, New York; Netherton, Robert C., Shaker Heights; Neubauer, Richard J., Norwood; Painter, Samuel L., Cincinnati; Peck, Jr., Warner A., Cincinnati.

Preston, Robert H., Cincinnati; Reece, Ralph C., Cincinnati; Riesser, John F., Cincinnati; Rubenstein, Eli, Cincinnati; Schafer, George E. Ft. Wayne, Ind.; Scheuerle, Roland F., Cincinnati; Schiff, Edward J., Cincinnati; Schmerge, John C., Norwood; Schmutzler, Walter A., Staunton, Ill.; Schneider, Edward M., Cleveland.

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Mullen, Charles J., Pomeroy, Hahnemann Medical College; Nisbet, Dick M., Eaton, Northwestern University; Plunkett, John P., Cincinnati, University of Chicago; Porterfield III, John D., Columbus, Rush Medical College; Redyman, Melvin M., Cleveland, University of Wisconsin; Rees, Robert, M., Akron, Temple University; Stiff, Philip C., Toledo, Loyola University; Stone, Richard L., Cincinnati, Hahnemann Medical College; Storer, John, East Cleveland, Hahnemann Medical College; Svedberg, Arthur H., East Cleveland, Hahnemann Medical College.

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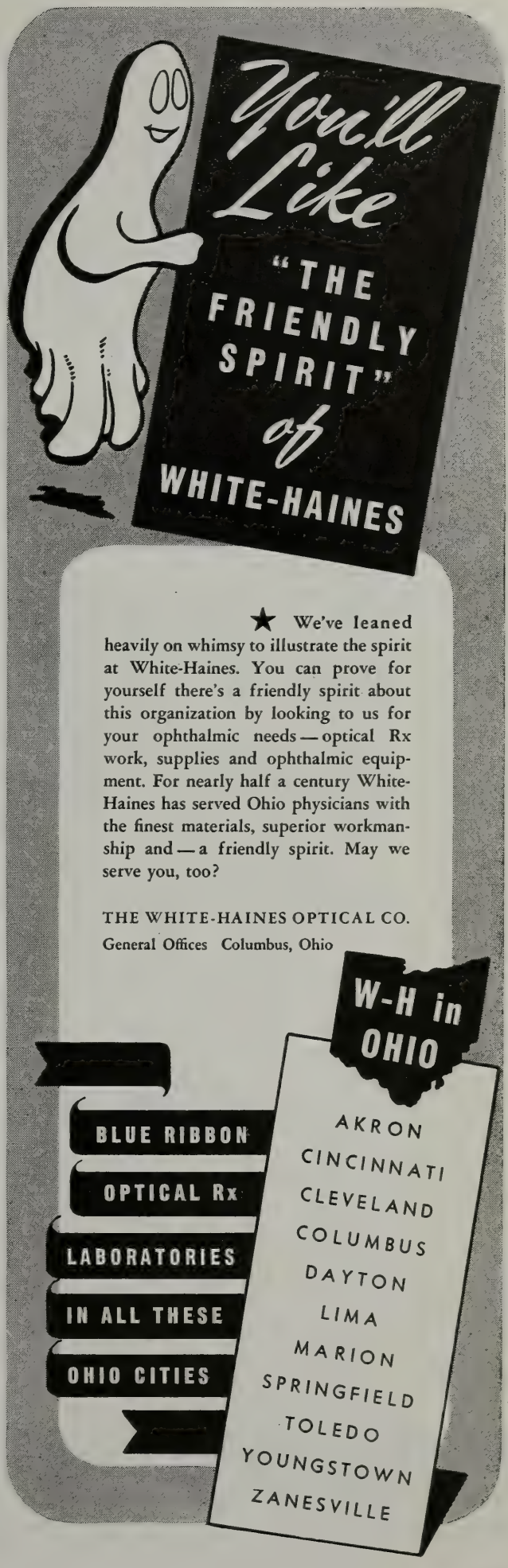
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ACTIVITIES OF COUNTY SOCIETIES

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

HAMILTON

How certain stomach disorders and other ailments are affected by the emotions was discussed by Dr. Harold G. Wolff, associate professor of internal medicine, Cornell University Medical School, before the Academy of Medicine of Cincinnati at the Academy Auditorium April 16.

On May 7, Dr. Frank H. Lahey of the Lahey Clinic, Boston, spoke on "The Management of Lesions of the Terminal Ileum, Colon, and Rectum". Dr. Lahey was national chairman of the Procurement and Assignment Service and chairman of the Medical Consulting Board of the United States Navy during World War II. During World War I he was Chief of the Surgical Service, Base Hospital 30.

Dr. Walter L. Palmer, professor of medicine, University of Chicago Medical School, presented a paper on "The Nature and Treatment of Peptic Ulcers", at the May 21 meeting of the academy.—Bulletin.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

MIAMI

Dr. L. Howard Schriver, Cincinnati, addressed the Miami County Medical Society at the Troy Country Club on April 4 on the prepayment plan of Ohio Medical Indemnity, Inc., and the American Medical Association's Associated Medical Care Plans organization which has been recently established to coordinate the existing prepayment plans.

Dr. Schriver is immediate past-president of the Ohio State Medical Association, having completed his service as president at the Centennial Anniversary Meeting of the Association in May, and is the president of Ohio Medical Indemnity, Inc.

Fourteen Miami County physicians who have served, and are serving in the armed forces were honored at the Miami County meeting.

Dr. Marion Coleman of Dayton presented a paper on "Cystitis in Women" at the May 3 meeting of the society at the West Milton Inn in West Milton. Dr. Coleman has recently returned from a long period of service with the Navy in the Pacific.—G. A. Woodhouse, M.D., secy.

MONTGOMERY

At a meeting of the general practice section of the Montgomery County Medical Society, held April 28 at the Miami Hotel in Dayton, new health laws were reviewed by Dr. H. H. Pansing, county health commissioner, and Dr. H. H.

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Williams, Dayton health commissioner. Members recommended that at least three general practitioners be placed on the Metropolitan Health Council.

Dr. M. M. Zinninger, acting director, department of surgery, University of Cincinnati Medical College, spoke on "Surgical Management of Patients with Jaundice", at the May 3 meeting of the Montgomery County Society held in the Hotel Van Cleve, Dayton.

Members of the society were entertained by the medical staff of the AAF Regional State Hospital, Wright Field, Dayton, on May 15. "Use of Intramedullary Bar for Fractures of the Femur and Humerus" was discussed by Captain Dana Street; "Treatment of Venereal Diseases in the Army", by Captain Charles Froug; and "Acute Appendicitis", by Captain Leo H. Pollock. Golf and dinner were included on the program.—N. E. Leyda, M.D., pres.

Third District

(COUNCILOR: J. CRAIG BOWMAN, M.D., UPPER SANDUSKY)

Having served three terms as Councilor of the Third District of the Ohio State Medical Association, the maximum number of terms permitted by the by-laws of the organization, Dr. Guy E. Noble, St. Marys, entertained 86 members from the 11-county district with a dinner party at Idlewild clubhouse, Lake St. Marys, April 28. The meeting was held just before the Centennial Meeting of the Association when Dr. J. Craig Bowman of Upper Sandusky was elected to fill the position left vacant by Dr. Noble. Dr. George Harding of Columbus, and Dusty Miller of Wilmington were guest speakers.

HANCOCK

Dr. R. H. Markwith, assistant chief medical officer of the Cleveland Veterans' Administration Hospital, addressed the Hancock County Medical Society at its dinner meeting in the Elks Home, Findlay, April 18. Dr. Markwith's subject was "Procedure to Treat Service-Connected Disabilities of Veterans at Government Expense".—News clipping.

Fourth District

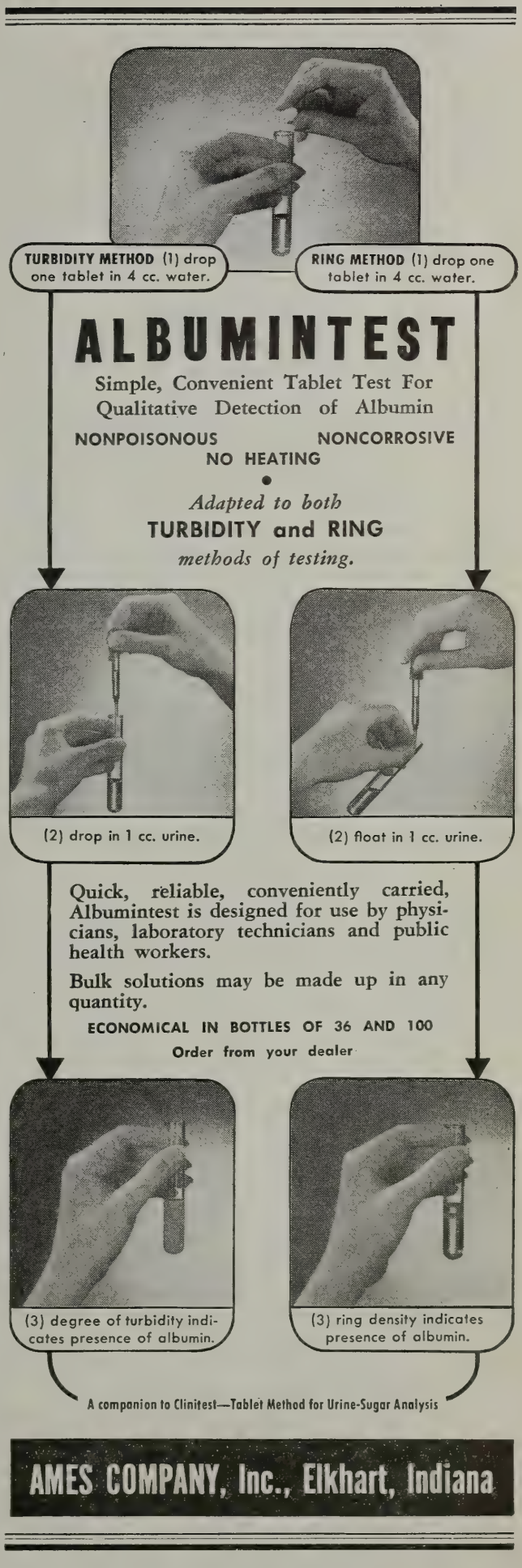
(COUNCILOR: A. A. BRINDLEY, M.D., TOLEDO)

LUCAS

The Academy of Medicine of Toledo and Lucas County sponsored its 18th annual postgraduate course in psychosomatic medicine, April 17 through 19, for members of the academy.

At the general meeting of the academy May 3, in the Academy Building, Dr. Norman F. Miller, of the department of obstetrics and gynecology, University of Michigan, presented a paper on "Hysterectomy".

May 24—"The Treatment of Intestinal Ob-



struction", Dr. M. M. Zinninger, department of surgery, University of Cincinnati.

May 31—"Emergencies of the Eye of Interest to the General Practitioner", Dr. Louis Ravin, Toledo. "Emergencies of the Ear, Nose, and Throat of Interest to the General Practitioner", Dr. J. E. Minns, Toledo.

The returned war veterans' committee of the academy met on the evening of May 6 at the Academy Building.—Bulletin.

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

CUYAHOGA

At a special meeting of the Academy of Medicine of Cleveland in cooperation with the Western Reserve University School of Medicine and the Division of Health of Cleveland at the Medical Library Auditorium April 30, Dr. N. J. Eastman, professor of obstetrics, Johns Hopkins Medical School, presented a paper on "Prematurity From the Obstetrical Standpoint", and Dr. J. L. Wilson, professor of pediatrics, University of Michigan, discussed "The Care of the Premature Infant".

The annual meeting of the academy, which honored members returned from the war service, was held at the Medical Library May 17. The speaker was Brig. Gen. Elliott C. Cutler, professor of surgery, Harvard University Medical School, whose topic was "Experiences of an Army Doctor in the European Theater of War".—Bulletin.

GEAUGA

The Geauga County Medical Society met with Dr. W. C. Corey in Chardon, April 24. Dr. Dixon, the District Councilor, was the guest speaker. He discussed a number of matters scheduled for action at the State Association Meeting.—Isa Teed Cramton, M. D., secy.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M.D., AKRON)

PORTAGE

The Portage County Medical Society met on May 2 at the Robinson Memorial Hospital in Ravenna. A colored motion picture on surgery was shown at the meeting. The picture, by Dr. Harry E. Bacon, Temple University School of Medicine, was shown by a member of the professional service department of Frederick Stearns & Co.—E. J. Widdecombe, M. D., secy.

SUMMIT

The Summit County Medical Society heard Dr. Harold N. Cole, professor of dermatology and syphilology, Western Reserve University School of Medicine in a discussion on "Newer

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OBSTETRICS—Two Weeks Intensive Course starting October 7.

MEDICINE—Two Weeks Intensive Course starting June 17 and September 23.

ELECTROCARDIOGRAPHY & HEART DISEASE—Two Weeks Intensive Course starting August 5.

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Methods of Treating Syphilis", at the May 14 meeting at City Hospital in Akron.—Bulletin.

TRUMBULL

On April 18 a motion picture on nutritional deficiencies was shown at the meeting of the Trumbull County Medical Society at Warren. May 18 was ladies' night and a dinner dance was included on the program. Dr. J. C. Henshaw, Warren, who has been in practice 50 years, was honored.—E. G. Caskey, M. D., secy..

Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

HARRISON

The Harrison County Medical Society and the Woman's Auxiliary met April 17 at the home of Dr. and Mrs. J. M. Scott, at Scio. Guest speaker was Dr. John Bevan of Steubenville, who presented a paper on the use of magnesium sulfate. —News Clipping.

JEFFERSON

Dr. John Tucker of the Cleveland clinic addressed members of the Jefferson County Medical Society on the subject of headache at the Ohio Valley Hospital, April 17.—News Clipping.

Eighth District

(COUNCILOR: A. J. TRONSTEIN, M.D., NEWARK)

The May meeting of the Muskingum County Academy of Medicine was held May 1 at the University Club, Zanesville. Dr. R. S. Martin, Zanesville, gave a case report on "Aneurism of the Internal Cartoid".—News Clipping.

GUERNSEY

Dr. Henry L. Wells of Cambridge addressed members of the Guernsey County Medical Society at their noon meeting April 5 at the Berwick Hotel in Cambridge. His subject was "Starvation Psychosis".—News Clipping.

Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

HOCKING

The May 1 meeting of the Hocking County Medical Society was held at the Hocking Valley Hospital. After a 6 o'clock dinner routine business was conducted.—Owen F. Yaw, M.D., secy.

LAWRENCE

Dr. H. E. Martin, Ashland, Kentucky, just returned from duty with the army, addressed the Lawrence County Medical Society on "Treatment of Venereal Disease" at a meeting held April 23 at the Elks Lodge in Ironton.—News Clipping.

SCIOTO

Dr. Louis M. Piatt of Columbus addressed the Hempstead Academy of Medicine on the subject

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"Radium and Radio-Active Substances" during the April 8 meeting of the group at the Portsmouth General Hospital. Films on gastro-intestinal lesions were also a part of the program. Dr. T. G. McCormick of Portsmouth was committee chairman for the meeting.—News Clipping.

PICKAWAY

Dr. H. D. Jackson described some of his experiences in World Wars I and II at the monthly meeting of the Pickaway County Medical Society held in Circleville, April 6. It was decided to continue the monthly meetings of the organization during the Summer.—News Clipping.

Tenth District

(COUNCILOR: H. M. CLODFELTER, M.D., COLUMBUS)

FRANKLIN

On May 6, Dr. Charles A. R. Connor, of the department of medicine, New York University, presented a paper on "Rheumatic Fever, Problems in Diagnosis and Management of the Various Phases of the Disease" at the meeting of the Columbus Academy of Medicine in the Art Gallery, Columbus. Dr. Connor was a special consultant in the Rheumatic Fever Control Program of the Army Air Forces. Dr. Florence R. Lenahan, Columbus, was the discussant.

On May 20, Dr. Charles A. Doan, dean of the College of Medicine, Ohio State University, discussed "The Development and Therapeutic Uses of Folic Acid".—Bulletin.

Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

LORAIN

Dr. Claude S. Beck, Cleveland, spoke on "Heart Surgery" at the regular meeting of the Lorain County Medical Society, held May 14 at Castle-on-the-Lake, Lorain.—L. H. Trufant, M. D., secy.

Do You Know - - -

The Army Medical Department has announced that all civilian inquiries and requests for supplies of streptomycin to be used in treating civilian cases are to be sent to Dr. Chester S. Keefer, Evans Memorial Hospital, 65 East Newton, Boston, Mass., telephone Kenmore 9200. Dr. Keefer is chairman of the Committee on Chemotherapeutic and Other Agents of the Division of Medical Sciences, National Research Council. He has been authorized to handle civilian requests, providing they are submitted by a physician giving sufficient technical information to enable him to decide whether streptomycin is indicated in the treatment of the case.

* * *

George H. Saville, director of public relations for the Ohio State Medical Association, explained the medical profession's program for better distribution of medical care and its attitude on the Wagner-Murray-Dingell bill at recent meetings of the Toledo Lions Club and the Middletown Rotary Club. He also spoke to the Medical Review Club of Columbus on "What's Going On In Washington".

* * *

Three members of the Cleveland Academy of Medicine have been added to the Board of Trustees of the Cleveland Health Museum. They are: Dr. Harold Feil, Dr. Russell B. Crawford, and Dr. Herbert Wright.

CLASSIFIED ADVERTISEMENTS

Rates: 50 cents per line, payable in advance. Minimum charge of $1.00 for each insertion. Price covers the cost of remailing answers. Forms close 16th of the month preceding publication.

WANTED: Physician for locum tenens. Write for information. 200 Republic Building, Cleveland, Ohio.

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FOR SALE—X-ray equipment which was in operation until October, 1942, and has been stored since that time: X-ray table with horizontal fluoroscope and overhead radiographic assembly; Engeln control unit; curved Bucky diaphragm; transformer; three 30 milliampere air cooled self rectifying tubes; fluoroscopic screen; one 8 x 10 cassette; developing tanks. May be connected for 110 or 220 volt 60 cycle power source. Not shockproofed. Will sell for $400 as is. Box W, Ohio State Medical Journal.

FOR SALE: Kelley Koett X-ray therapy with new shock proof tube and also a fever cabinet. Dr. W. H. Miller, 328 E. State St., Columbus 15, Ohio.

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Vol. 42 JULY, 1946 No. 7

JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.*

GEORGE H. SAVILLE, *Asst. Managing Editor*

HART F. PAGE, *News Editor*

The Hazards of Tropical Diseases as a Result of World War II

PHILLIP T. KNIES, M.D.

SERIOUS consideration was given throughout the war to risks of introducing exotic diseases and other harmful agents into the United States through the traffic of war and the return of military personnel from abroad. Estimates of hazard varied widely, but the most critical epidemiological analyses anticipated little risk in most instances. This was the viewpoint also of the Interdepartmental Quarantine Commission jointly established by the Secretaries of War and Navy and the Administrator of the Federal Security Agency to study this problem. Precautions recommended by the Commission were established in special quarantine programs of the Armed Forces.

With the end of fighting and return of the bulk of combat forces, it is now possible to review actual results on a preliminary basis. Optimistic conclusions appear warranted though tentative. No acute outbreak or secondary spread of imported disease has been reported to date in the United States* and while more slowly evident infections may yet be identified, it must be remembered that traffic and return have now gone on for four years.

Malaria has always received priority consideration among risks to the public health of this country as a result of the war. Aiming primarily at maintenance of fighting efficiency, the Army and Navy greatly emphasized prevention and suppression of this disease. Although malaria remained the commonest infectious disease of troops abroad, the 440,000-odd reported hospitalizations of Army personnel from the onset of war through August, 1945 are far below pessimistic anticipation. As this figure includes both initial and recurrent infections, the total of persons involved was appreciably smaller.

Former Chief, Quarantine Branch, Office of the Surgeon General, and Army Quarantine Liaison Officer.

The Author

● **Dr. Knies, Columbus, Ohio, is a graduate of Ohio State University College of Medicine, 1931; diplomate, American Board of Internal Medicine; fellow, American College of Physicians, American College of Chest Physicians; member, American Public Health Assn., American Society of Tropical Medicine; senior attending staff, University and Mt. Carmel Hospitals; and assoc. clinical prof. of medicine, Ohio State University College of Medicine.**

Malaria is not susceptible to practicable border quarantine, and prolonged detention of returning personnel in segregation areas to avoid dissemination of the infection among the general populace was deemed unfeasible and unnecessary. Considering that only a portion of persons infected abroad are liable to recurrence after return to the United States (about 60,000 military hospitalizations to July 1, 1945) and that these will be diluted among the 130-odd millions in the country, often in non-malaria-supporting areas, it is evident little community risk is afforded. Multiples of this risk are offered annually by endemic malaria in the United States, and fears of exceptional virulence and resistance to treatment on the part of foreign strains have not been borne out. What risk does exist has been anticipated by the U. S. Public Health Service in extensive mosquito control projects in communities and about military installations in susceptible areas. Some returned military personnel will, of course, have recurrences of malaria, and local outbreaks may result as following previous wars, but these should remain minor and readily controllable by modern improved measures.

Historical experience indicated the general risk offered even in normal traffic by cholera, smallpox, plague, epidemic typhus, and yellow fever. Their special danger in war is a matter of record. These are the internationally quarantinable diseases, and safeguards established against them by international conventions recognize both their importance and their susceptibility to border quarantine techniques. Immunizations were employed against all of them by the Armed Forces along with water control, environmental sanitation, and disinfestation and insect control by newly developed methods. These precautions were exercised even under combat conditions, as parts of preventive medicine toward combat efficiency. Results were evident. Smallpox occurring in the Army overseas was limited to 81 cases along with 63 of typhus and 13 of cholera through September, 1945. There were no cases of yellow fever or of plague.

Elaborate quarantine procedures in traffic to the United States were established by both Services, based on selective accomplishment of the above protective measures before departure from abroad. Only three cases of smallpox have occurred to date in Army traffic to this country, and these arrived in patient status with full attention to all contacts.* No cases developed after entry. One mild and atypical infection with typhus was recognized in himself by a medical officer on arrival in the United States after special work with the disease. Eleven typhus infections occurred among prisoners of war brought to the United States. No secondary cases developed, all prisoners having been disinfested before shipment and again inspected on arrival. It is apparent that risk of the quarantinable diseases has been negligible.* It may also be pointed out that several hundred cases of endemic smallpox are reported annually in the United States; twelve occurred among military personnel during the war.

Eight lepers were returned from Army personnel abroad in the past four years; all but one had a previous family history of the disease and none are considered contracted abroad, (nine others were detected before shipment overseas). Three Japanese and one Italian prisoner were leprous and were hospitalized during their entire stay. Had all these been new and unrecognized infections they would not have equalled the acknowledged normal risk in New York City alone.

Scrub typhus or tsutsugamushi disease has been reported in 6,800 cases. Other than one instance, no active infection has been recognized after return to the United States. This was to be expected from the short incubation period of the disease and the fact that it is usually contracted in field exposure. Persons so occupied are not likely to return to this country suddenly. Nor are infected mites likely to survive transportation in clothing or salvage in view of their fragility. Sandfly fever, of which some 12,000 cases were reported, is subject to similar limitations, and no cases have been recognized after return.

Dengue is sporadic in certain southern states and a handful of cases occurred there each year among troops. No case has been recognized among persons returning from overseas to the continent. Nevertheless, the disease did occur in Hawaii beginning in 1942, probably introduced by returnees from forward areas in the Pacific. Vigorous control was instituted in cooperation with Territorial authorities. The outbreak was well controlled, and no case has been reported now for several months.

Filariasis was much feared in some quarters early in the war, primarily as a hazard to troops themselves. All recognized cases were evacuated from endemic areas at once and slightly over 2,000 diagnoses have been made in the Army. None of these cases showed chronic elephantiasis which would be expected only from prolonged exposure and repeated infections. Microfilariae have been found in the blood with the greatest rarity. Even concentration techniques have failed routinely to show them, and risk to the general populace is obviously negligible.

Leishmaniasis has been diagnosed 344 times including both cutaneous and visceral forms. No secondary cases have been reported. In view of the vigorous treatment accorded these infections and the necessity for all elements of an intermediate mechanism before transfer can occur, introduction of the disease into this country is most unlikely. The same pertains to relapsing fever, 241 cases of which have been reported almost evenly inside and outside the United States. That it was predominately, if not entirely, tick-borne is suggested by the control of louse-infestation of troops, without which a different problem might have been presented. Self-limitation and fortunate susceptibility of the disease to therapy, and emphasis on control of lice and other insects among troops, comprise the protection of our civilian population. Furthermore, relapsing fever, as mite typhus, is a disease of field conditions, and it is again improbable that persons recently exposed often will be returned within the incubation period. Once ill, they can be treated effectively before travel.

Onchocerciasis, trypanosomiasis, guinea-worm, and yaws have not been experienced in U. S. troops. In the last analysis, the common illnesses abroad, including the tropics, are those which are common at home, and with the exception of combat injuries the same pertains to disabilities in war.

Schistosomiasis was contracted by some 1,200 men, mainly on Leyte, and for reasons already

indicated additional significant numbers need not be expected hereafter, even among garrisons in infected areas. These cases have generally been mild, and because exposure was of limited duration the late cicatricial changes, which underlie the disability of indigenous cases, will probably rarely occur. For the same reason, dissemination of ova should be infrequent, but principal protection of the homeland community will be afforded by its generally excellent sewage disposal. Furthermore, it has not been shown, despite intensive search, that any domestic snail is suitable for the life cycle of the oriental disease in the United States. In any event, risk from service personnel will probably not approach that associated with schistosomiasis mansoni in imported farm labor from Puerto Rico.

Amebiasis and bacillary dysenteries have occurred, too, but foreign strains have appeared no more virulent than those already widely disseminated in the United States. It has already become evident that chief protection against these diseases,, including ancylostomiasis, lies in well recognized and widely applied principles of waste and water care.

Approximately 20 soldiers have been diagnosed as having Japanese-B encephalitis. Considerable apprehension attached to this disease, and the small number of cases to date is highly gratifying. Lack of established epidemiology is most impressive in evaluating risk to this country. Despite demonstration of mosquito vectors, the unknown rather than the known underlies our apprehension. This has been true of many diseases in history. Much comfort is gained from the proved preventive value of distance, small numbers of carriers, dilution, and continuing military alertness and medical care. Should significant outbreaks occur abroad, it is axiomatic that the full military program of preventive medicine will be applied, including probably immunization.

Much attention has been devoted by the Army and Navy to possible introduction into the United States of new species of vector insects. Disinsection of aircraft was made a responsibility of flight personnel under supervision of the Medical Department and is routine at stations of take-off for this country. To date, there is no evidence that any alien form has been implanted. It is possible this might not be apparent as yet.

As previously stated, a report must be tentative at this time. Nevertheless, favorable conclusions seem strongly justified. Despite unprecedented breadth of travel and exposure, the military forces of this country in World War II have not subjected the United States to significant risk of disease from abroad.

This has not been the result of any single factor, but rather of the entirety of modern preventive medicine applied intensively by both Army and Navy. Exotic disease did occur and breaches of formal quarantine are acknowledged. But extensive investigation of likely hazards and critical application of preventive and corrective measures were effective in reducing risks to small proportions. This was undertaken first to preserve effectiveness of combat forces through protection of personnel in the field. Primary efforts were directed therefore to local risks and to men exposed to them. Measures included immunizations, protective clothing, insect repellents, water purification, waste disposal, mosquito and other insect control, and additional environmental sanitation. The development and widespread adoption of suppressive medication and insecticides, and education of men and their officers to risks incurred were parts of this program. Quarantine precautions were established which took maximum advantage of the preventive care of the individual to assure safety to countries of entry. This was a re-orientation of quarantine procedure which is ordinarily directed at momentary observation when international borders are crossed. The military technique is fully applicable only when the responsible agency has control of the traffic throughout, but the prinicples involved should be of advantage in further development of international health measures.

Further protection has been afforded the United States after entry of military traffic. Thus personnel generally remain under military medical care for the duration of the important incubation periods, hospitalization has been available for the sick, and none have been returned to civilian status until maximum benefit has been offered. This has minimized risk to the patient and to his community.

A final link in protection of this country is the generally high level of sanitation, insect control, and medical care here available. Their continued assurance is a special responsibility of organized medicine. The total effect of the several factors herein discussed is a defense in depth based on broad application of preventive medicine, an essential field of medical science never developed so fully as during the recent war.

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*Subsequent information requires revision of this statement. One soldier who arrived in San Francisco by air in patient status for neuropsychiatric disease on December 28, 1945, in the incubationary stage of smallpox is considered the starting point of infection for six subsequent civilian cases. The mode of first secondary infection is uncertain but apparently indirect. Two other military cases arrived at this port in patient status because of smallpox on March 29 and April 8, 1946; no apparent secondary infections occurred. In Seattle, a diagnosed case of smallpox entered in patient status on February 5, 1946 and was hospitalized immediately. The first secondary case was a patient in that hospital, vaccinated on February 6 with a primary reaction, whose smallpox began on February 16. Most of the remainder of 40 cases which occurred in Seattle seemed traceable to this second person; routes of infection in the remainder were uncertain. In Los Angeles a diagnosed case of smallpox entered January 28, in patient status; no secondary infection occurred. A customs official in San Diego was diagnosed as having smallpox about March 5, 1946; no definite source was determined and secondary cases did not occur.

Poliomyelitis Analysis

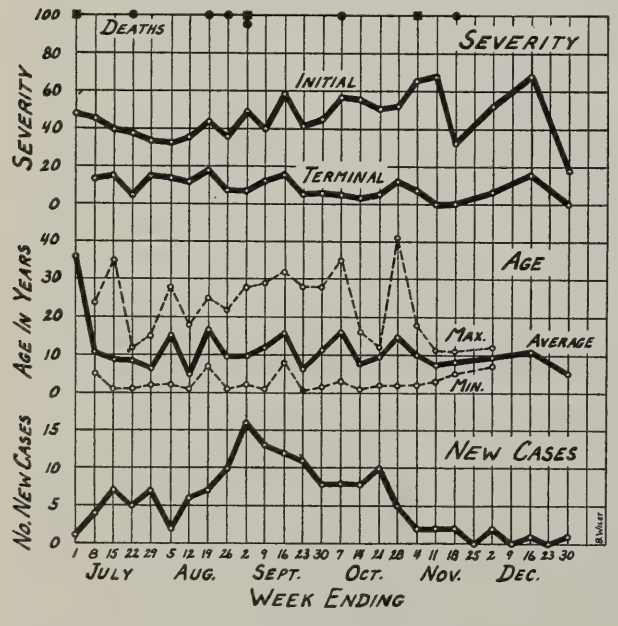
BERT C. WILEY, M.D.

THE following data and observations were compiled from the series of 150 definite poliomyelitis cases treated at the Miami Valley Hospital, Dayton, Ohio, from July 2, to December 30, 1944.

TREATMENT

As soon as the diagnosis was established, the patients were transferred to a Polio Building where bedboards, footboards, and firm mattresses were standard equipment. Hot wet packs prepared in a self-heating electric washing machine with wringer[1] were applied to the spastic muscles at least eight times a day. Physiotherapists gave passive motion and muscle training four times a day as early as tolerated. Sitting, standing, and walking were encouraged as soon as the patient could do so without weakening the muscles or developing incoordination. Braces and crutches were used wherever they speeded the patient's recovery, and they were then discarded as soon as the patient could get along without them.

Most of the patients were sufficiently recovered to return home at the end of the Ohio three-week quarantine period, and were followed up as long as a year if their condition warranted. The more severely affected patients were treated in convalescent wards until a satisfactory or apparently maximum recovery was reached.



Season Graph No. 1.

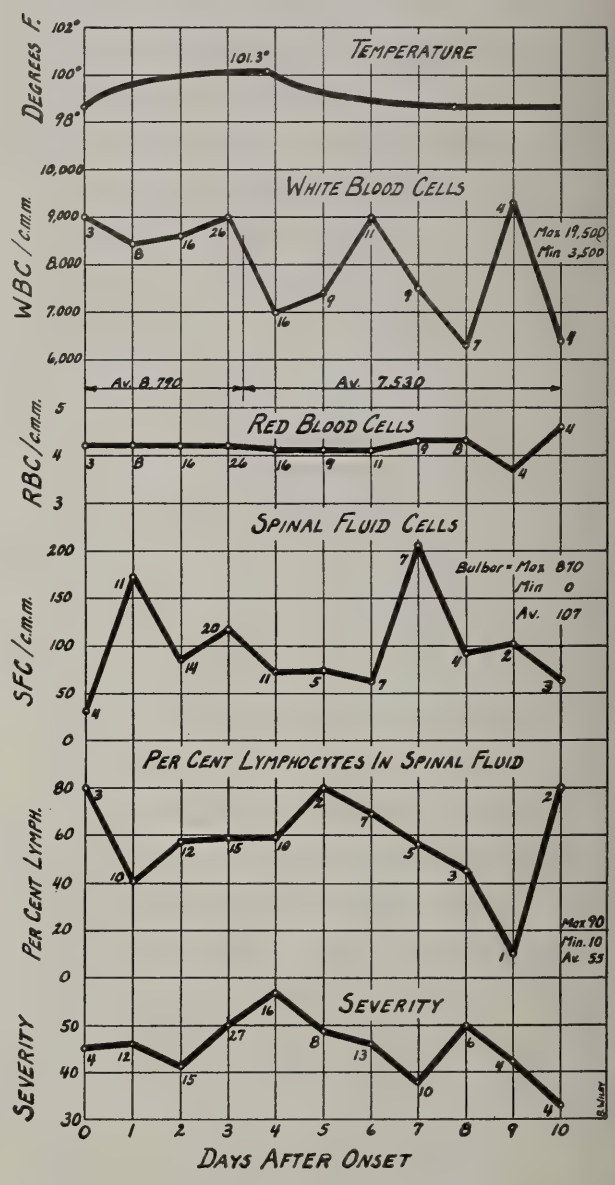
Squares refer to males, and circles to females.
Initial severity was the admission severity of fatal cases, and the peak severity of all others (See Table No. 2).
Terminal severity was the condition of the patient at the time of the latest checkup.
Ages were averaged for each week.
New cases refer to the total number of patients having onsets during each week.

Submitted April 8, 1946.

The Author

● Dr. Wiley, Dayton, Ohio, is a graduate of Ohio State University College of Medicine, Columbus, 1943; member, American Congress of Physical Medicine; and director, Department of Physical Medicine, the Miami Valley Hospital.

The Season and Laboratory Graphs No. 1 and No. 2 are self-explanatory.



Laboratory Graph No. 2.

Only the time after onset and the height of the peak temperature, and the time to regain normal temperature are plotted.
Each other plotted point indicates the average for all patients upon whom that test was made at the same time-interval after onset. The number of patients involved in each calculation is noted beside the plotted average.
The severity of the patients involved in each calculation was averaged as of the time the laboratory tests were made (See Table No. 2).

TABLE NO. 1—CLINICAL FINDINGS

The clinical findings up to the time of admission are given in the order of their frequency of occurrence. In the case of bilateral muscles, the percentage refers to the possible involvement of both sides.

	Onset Symptoms		Muscles in Spasm		Muscle Weakness	
1.	66.0 %	Stiff neck	71.3 %	Post. neck	66.0 %	Sterno.
2.	64.6	Muscle pain	69.2	Back	59.3	Abdom.
3.	60.6	Fever	57.0	Quad. lumborum	52.6	Glutei
4.	51.3	Stiff neck	48.6	Hamstrings	50.0	Iliopsoas
5.	43.3	Headache	22.4	Adductors	46.3	Quadriceps
6.	40.0	Malaise	18.6	Iliopsoas	30.6	Tibialis ant.
7.	31.8	Non-use of an extremity	15.0	Pectoral	30.3	Hamstrings
8.	31.3	Mental irritability	6.33	Quadriceps	30.0	Peroneal
9.	30.0	Emesis	5.33	Trapezius	30.0	Tibialis post.
10.	29.3	Nausea	5.0	Biceps hum.	28.0	Adductors
11.	27.4	Sore throat	3.66	Toes	26.0	Toes
12.	18.0	Abdom. dyspnea	3.0	Glutei	22.6	Gastro-soleus
13.	17.3	Rectal retention	3.0	Tibialis ant.	20.3	Rhomboids
14.	15.3	Food dysphagia	2.0	Peroneal	19.3	Coraco.
15.	13.3	Speech dysarthria	2.0	Coraco.	19.0	Deltoid
16.	12.65	Water dysphagia	1.33	Abdom.	16.0	Triceps
17.	12.65	Cutaneous irritability	1.33	Deltoid	14.65	Back
18.	12.6	Urinary retention	1.33	Sterno	13.3	Biceps
19.	8.67	Mucus dysphagia	1.33	Teres major	12.3	Pectoral
20.	6.0	Cyanosis	1.33	Tibialis post	11.0	Teres
21.	4.66	Sternal dyspnea	1.33	Triceps	9.0	Trapezius
22.	4.66	Rib paralysis	0.66	Eye	8.6	Forearm
23.	1.33	Rash	0.66	Latissimus	7.65	Quad. lumborum
24.	0.66	Flushed skin	0.66	Rhomboids	7.3	Pharyngeal
25.	0.66	Eye			6.66	Hand
26.					4.0	Post neck
27.					0.66	Facial
28.					0.66	Latissimus

TABLE NO. 2

Scale of Prognosis and Functional Impairment	
Neck and/or back involvement	2½ or 5%
Pharyngeal involvement	5
Respiratory involvement	5
Facial and/or eye involvement	5
Rectal and/or bladder involvement	5
Morbidity	5
Any weakness of an arm	2½
Any paresis of a hand	5
Any paresis of an elbow	5
Any paresis of a shoulder	5
Any weakness of a leg	2½
Any paresis of an ankle	5
Any paresis of a knee	5
Any paresis of a hip	5

OBSERVATIONS

1. Only one patient, a five-year old colored boy, gave a history of having had a previous attack of poliomyelitis. Although his history could not be checked, the patient did have a moderate amount of atrophy and a slight shortening of his right leg. He made a very rapid improvement to complete recovery of his current attack. This series included only three colored patients: a 16-month old girl, an 18-month old boy, and the above five-year old boy.

2. There were only four family groups, with 6 to 16 days between onsets:

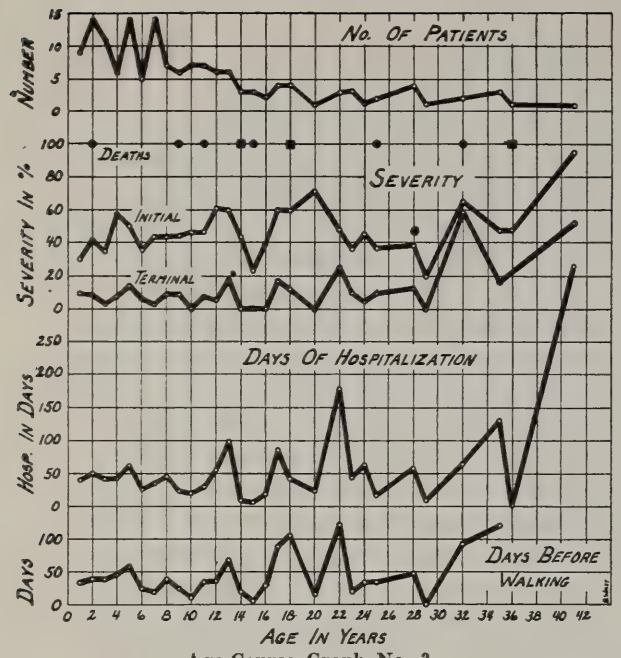
(a) Son and father 5 and 41 years of age.
(b) Brothers 1½ and 3 years of age.
(c) Brothers 1½ and 2½ years of age.
(d) Cousins: girls 1 and 5 years old and a boy 2 years of age.

3. The chief common predisposing factor to extreme initial severity appeared to be muscle over-fatigue:

(a) The high-school girl who mixed concrete.
(b) The business man who loaded a truck of cement.
(c) The adolescent boy who excessively bicycled on a newspaper route.
(d) The farmer who was encouraged to ignore his muscle pain and spasm, and to continue to operate his tractor until paralysis set in.
(e) The housewife who spaded her garden to the point of exhaustion.
(f) The high-school boy who split fence posts.

4. Four out of the fourteen females 22 years of age or over, were pregnant for 3½, 5½, 6, and 8½ months at the time of the onset of their poliomyelitis. Of these, one died before delivery; the other three had normal deliveries with normal children, one made a complete recovery, while two suffered functionally significant impairment.

5. Since there were only fifteen patients in this series who received sulfonamides during



Age-Course Graph No. 3.
The number of patients refers to those admitted at each age.
Squares refer to males and circles to females.
Initial severity was the admission severity of fatal cases, and the peak severity of all others (See Table No. 2).
Terminal severity was the condition of the patient at the time of the latest checkup.
Hospitalization days includes all elapsed time the patient was under treatment in an institution as a resident patient.
Walking indicates the total time from onset of the disease until the patient was able to walk. The 41-year old male is the only patient who has not yet walked satisfactorily.

their acute poliomyelitis stages, sound conclusions as to the effects of these drugs upon poliomyelitis patients can not be made, yet the following observations are significant: These patients averaged 23.6 per cent greater initial severity, 34.6 per cent greater terminal severity, and were hospitalized 27.7 per cent longer than the entire group as a whole.

6. Likewise, the findings upon the only two patients with recent T and A's (9 and 21 days prior to onset) are of interest, since they averaged 18 per cent greater initial severity, 65.9 per cent greater terminal severity, and 30.2 per cent less hospitalization than the entire group as a whole.

TABLE NO. 3—
DISTRIBUTION OF INSTITUTIONAL CARE

Per cent of Total Patients	Per cent of Total Hosp. Days	Range of Hosp. Days	Average Hosp. Days
4.7	.7	0-10	7.3
31.3	10.9	11-20	16.8
14.	7.0	21-30	24.2
36.	11.6	0-20	15.5
50.	18.6	0-30	17.9
16.	55.	Over 100	165.3
12.	31.3	100-200	125.
4.	23.8	Over 200	286.

The Age-Course Graph No. 3 shows that the severity increases gradually with age. Patients over 30 years of age generally had a relatively poor prognosis, while the postpuberty ages of 14-16 years uniformly improved to complete recovery. A further breakdown of the age incidence showed that 22 per cent of the patients were between 5 and 7 years of age; 48 per cent were under 6 years; 66.6 per cent were under 11 years; and 74.6 per cent were under 13 years.

The comparison of the data for the thin vs. obese patients is essentially similar to that of the male vs. female patients because the female normally has a relatively greater amount of adipose tissue than the male. These observations will be discussed under Fat Solubility.

Since the residual condition of any poliomyelitis patient can not be ascertained definitely until five years have elapsed after the initial attack, Table No. 5 of our results only indicates the condition of our patients at the time of their latest followup.

LOW CALCIUM

An analysis of the data presented in this report together with epidemiological observations made upon these cases, led to the theory that the poliomyelitis virus requires ionized calcium for its propagation. Therefore, I devised and applied a treatment regime which includes the use of soft water, a low calcium, high carbohydrate, low vitamin D diet, and sodium acid phosphate, which has given the excellent results already reported.[2]

FAT SOLUBILITY THEORY

The comparison between the obese and the thin patients is evidence that the poliomyelitis virus produces a fat soluble toxin, or is itself fat soluble; and affects the cerebrospinal nerves in much the same way as the fat soluble anesthetics, such as ether, do by reaching potent concentrations in the myelin sheaths. The obese person has a greater amount of fat in which the toxin (or virus) is fairly uniformly stored, so that its concentration in the myelin sheaths does not reach a damaging level until a longer period after the actual beginning of the disease. Similarly, after the peak of the disease is passed, the total fat depots of the body will still retain a greater amount of the toxin (or virus) and therefore their elimination or destruction will require a longer time than in a thin person. Also, if the concentration of toxin (or virus) is kept in fair equilibrium among the various fat depots, the myelin sheaths of the obese person will continue to store damaging levels over a longer period of time, and so cause a greater amount of residual damage, since the extent of irreversible damage is increased by longer exposure to a damaging factor.

This theory explains why the most used muscles are more frequently affected (Table No. 1), and why excessive muscular exertion predisposes to greater severity (Obs. No. 3). Since the nerves and their myelin sheaths which supply

TABLE No. 4—PERTINENT DATA; GENERAL AVERAGE

		Min.	Max.	Male	Female	Thin	Obese
Average age years	10.35	7 mos.	41 yrs.	9.28	11.35	17.6	17.4
Total number of patients	150			72	78	11	11
Days onset till admission	3.71	0	16	4.32	4.66	3.45	5.9
Initial severity	45.55%	5%	95%	43.3%	46.3%	58.7%	44.0%
Terminal severity (141 patients)	9.04%	0%	57.5%	6.63%	11.35%	6.36%	23.2%
Days packed	23.2	0	21.5		(Female:	7	7
Days onset to sitting	15.8	0	14.03		(Male:	4	4
Days onset to standing	31.8	0	22.9				
Days onset to walking	42.0	0	31.4				

TABLE No. 5—RESULTS

	No. of Patients	Per cent
Complete recovery	61	40.6
Functionally insignificant impairment	54	36
Recovery or insignificant impairment	115	76.6%
Functionally significant impairment	7	4.6
Require braces OR crutches	8	5.4
Require braces AND crutches	8	5.4
Still indefinite dependency	3	2.0
Contractures	0	0
Deaths	9	6
Total	150	100. %

these most used muscles also have a higher metabolism, and therefore have a higher replacement rate for their lipoid elements, they more quickly acquire a higher concentration of the fat soluble toxin (or virus), than do the less used nerves, and so are damaged earlier.

Dr. Melvin Oosting, pathologist for this hospital, repeatedly found hard or tallow-like fat at the autopsy of children dying of poliomyelitis. This morbid finding further supports the theory that the poliomyelitis virus combines with ionized calcium, is then deposited in the fat depots (and myelin sheaths) because of its fat solubility and there, upon the cooling of the body, the calcium unites with the fat to form hard calcium soaps.

CURRENT TREATMENT

Beginning in October, 1945, we began adding mineral oil to our previous regime. Initially it is given in laxative doses, and later in tolerated h.s. doses, so that it will absorb the fat soluble toxin (or virus) and being non-absorbable itself, will thereby prevent the absorption of that toxin (or virus) into the body, and will remove it from the body in addition to its laxative action of mechanically clearing the intestinal tract generally including the presumed colonies of virus growing in the duodenum. The results have been so unexpectedly successful, that only two cases are here reported with the warning that no final conclusions can be drawn from them regarding the merits of this type of treatment.

CASE REPORTS

Case 1—H.G., a 15 year old high school girl, attempted to play ping pong on Friday of her first week back at school following scarlet fever. But after 45 minutes she developed severe pain in both hamstrings and glutei; nausea and low abdominal cramps began and she was unable to sit or stand. A slight fever persisted for about 36 hours. By the following morning she could stand unsteadily in moderate comfort for a short time, but by afternoon the extreme pain and weakness returned; by evening she was unable to move her ankles at all, and remained in this condition until admitted to this hospital at noon Sunday. A complete muscle examination showed spasm of her low back, posterior neck, both hamstrings, adductors, calves and plantar muscles, with only traces of muscle power in both entire legs, and practically complete flaccidity of both ankles. At 1:30 P.M. she was placed upon the low calcium, mineral oil, packing regime. By the following morning practically all spasm was gone, she was able to us all muscles against moderate resistance, and walked in the afternoon with only slight hyperextension of the right knee. Five days later she was dismissed home. She returned to school one week later, was allowed full activity in another month, and four months later still showed no residual damage.

Case 2—B.C., a 41-year old, 170-pound farm wife who had had several attacks of flu during the winter, suddenly on January 22 developed a numbness of all extremities with rapid paralysis of both eye lids and upper lip. Within the next few days she became very constipated, anorexic, and had a great deal of difficulty in swallowing with an increase in salivation. Shortly thereafter, she developed severe pains in the muscles of all extremities and her back. Weakness progressed until by February 5 there was practically complete paralysis of both entire legs, which persisted until admission on February 15 when she also showed moderate to extreme weakness of both entire arms. The low calcium, mineral oil regime with b.i.d. physiotherapy was immediately begun, and three days later she could make all arm movements against resistance, and showed at least a trace of muscle function in all leg muscles. One month later she was beginning to walk with crutches.

BIBLIOGRAPHY

1. Wiley, Bert C.: Poliomyelitis Equipment. Archives of Physical Medicine, 26:10 Oct., 1945.

2. Wiley, Bert C.: Preliminary Report: Low Calcium Treatment of Poliomyelitis. O.S.M.J., 41:12 Dec., 1945.

Observations on an Epidemic of Poliomyelitis

PERCY MINDEN, M.D.

DURING 1945, there occurred in Akron and its vicinity an epidemic of poliomyelitis. Except for the epidemic of 1944 this was the severest of its kind in this area in recent years. This report is an analysis of all those cases that were admitted to the Children's Hospital of Akron.

All cases originated in the City of Akron or its surrounding area, and each patient was treated under the direction of a member of the pediatric or orthopedic staff. As far as possible a uniform method of treatment was used for all. This consisted in the early application of hot wet packs to the affected parts. These were applied five to six times a day, at two and three-hour intervals. Passive motion was started within a few days and active motion as soon as possible depending primarily on the comfort of the patient.

SEASONAL AND AGE INCIDENCE

A total of 103 patients were diagnosed as having poliomyelitis, and of these, 43 were from the City of Akron, 16 from Barberton, and 44 from 30 different towns and villages, all within a 50-mile radius of Akron.

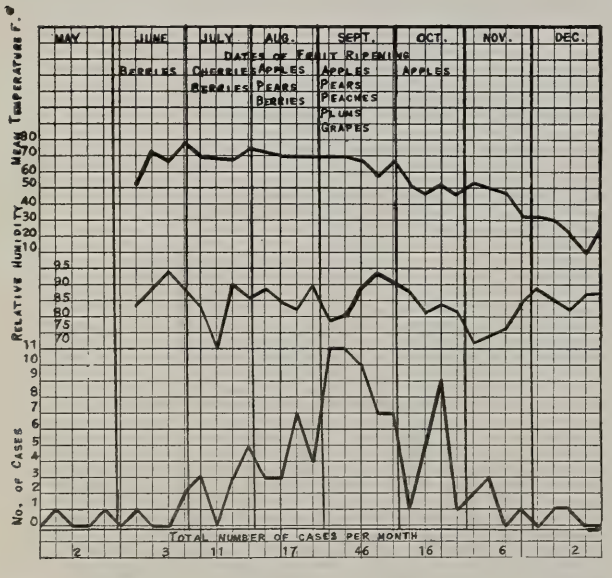


Figure 1. Weekly and monthly incidence of disease, showing relation to mean daily temperature, relative humidity and dates of ripening of fruit.

Figure 1 demonstrates the weekly and monthly incidence. A few cases occurred sporadically during the months of May and June, but the brunt of the epidemic occurred during August, September, and October. A peak was reached in the early part of September and there was a sudden second rise in incidence in October. In September alone, more than one-third of all the cases were admitted. Figure 1 also shows the average mean temperature and relative humidity during the months of the epidemic. There is no apparent correlation between these factors and the incidence of the disease. The dates of fruit ripening for this area are also indicated and it is seen that the majority of fruits ripened during September, the month with the greatest disease incidence. This was considered interesting in view of the fact that contaminated fruits and vegetables have been considered important agents in the transmission of the poliomyelitis virus.[1, 2]

Table 1 shows the age incidence of the epidemic. Ages ranged from 4 months to 17 years, with more than half occurring between the ages of 4 and 8. It was surprising to find that except for these ages most of the cases occurred between the ages of 1 and 2 or at the age of 14.

There was a slight preponderance of boys, to the amount of 57 per cent. Five pairs of patients came from identical families and were

TABLE 1. AGE INCIDENCE OF EPIDEMIC

Age	No. of Patients
Under one year	1
One to two years	7
Three years	5
Four years	8
Five years	12
Six years	18
Seven years	11
Eight years	8
Nine years	4
Ten years	4
Eleven years	6
Twelve years	5
Thirteen years	1
Fourteen years	7
Fifteen years	2
Sixteen years	3
Seventeen years	1

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brothers and sister. Another boy was admitted after his brother died of poliomyelitis at another hospital.

Of all 103 cases only two were noted in colored patients.

CRITERIA FOR DIAGNOSIS

Diagnosis was made by history and physical examination. Wherever possible the diagnosis was confirmed in our laboratory by examination of the cerebrospinal fluid. This was possible in all but 17 cases. In 6 of these, positive findings had been obtained in other hospitals from where the patients were transferred to us because of our facilities for treatment. Four other cases with a normal cerebrospinal fluid showed a sufficiently marked segmental type of paralysis of recent onset, to leave no doubt as to the diagnosis. The remaining 7 cases showed normal spinal fluid and although no muscle weakness or paralysis was found there was nuchal, spinal, and hamstring rigidity of a type strikingly similar to other cases of poliomyelitis that occurred during this time. Some of these cases were admitted too long after the onset to show positive findings in the spinal fluid. Several of these had contact with the disease in their own families and as every other cause for their symptoms had been ruled out they are included in this analysis.

CLASSIFICATION OF CASES

Table 2 shows the essential data of each case. In Table 3 is depicted the classification of all cases into five main groups.

1. Non-Paralytic Type. These showed no evidence of muscle weakness or paralysis at any time. There were 49 cases of this type, constituting 47.6 per cent of all.

A typical example of this group was case No. 24. A 7-year old white girl was brought to the hospital complaining of fever, headache, and back pain of two days' duration. Physical examination showed a well-developed and well-nourished girl, not acutely ill. There was considerable stiffness of the posterior neck, spinal and hamstring muscles. All tendon and superficial skin reflexes were present, active and equal. Cerebrospinal fluid showed clear fluid, contained 210 cells per cu. mm., 53 per cent of which were lymphocytes. The globulin test was positive. White blood count was 7,350. Treatment with hot packs was instituted at once. After three days, temperature returned to normal and tightness of all muscles began gradually to diminish. After careful physiotherapy and supervision, the child completely recovered and was discharged on her 35th day.

2. Spinal Type. This group showed definite spinal involvement as manifested by a segmental type of muscle weakness or paralysis occurring in muscle groups which received their innervation in the spinal cord. There were 34 of these, constituting 33.0 per cent of all.

Case No. 28 illustrates well the type of patient seen with the spinal type of involvement. This was a 5-year old white boy who was brought to the hospital with the following history. Five days prior he had a severe headache and fever that lasted three days. Two days before admission he developed weakness of both legs, so he could not walk. Examination showed an irritable, uncomfortable child that revealed at a glance, marked nuchal and spinal rigidity. There was also considerable stiffness of the hamstring muscles. The spinal fluid showed 53 cells, which were mostly lymphocytes, and the globulin test was positive. Muscle examination showed good power except for the left hip muscles. Tendon reflexes and superficial skin reflexes were present and equal. After a few days in the hospital marked weakness of all muscles about the left ankle was noted. Paralysis of the bladder developed and for a few days the patient had to be catheterized frequently. This condition cleared up spontaneously and completely. Although therapy was commenced at once the marked tightness of the boy's muscles persisted and it was only after 5 or 6 weeks that it appreciably diminished. On discharge, 58 days after admission, there was some slight weakness of all muscles of the left lower limb, and almost complete paralysis of all muscles of the left foot.

It is interesting to note that 7 of these cases exhibited bladder paralysis and except for one, this lasted only a few days and improvement was complete. The exception was a boy who had a congenital urethral stricture and could not be catheterized. A suprapubic cystotomy was done, and on improvement of the bladder paralysis a urethrotomy was performed and his bladder function improved uneventfully.

The degree of recovery that occurred in this group is indicated in Table 6.

3. Polioencephalitic Type. This diagnosis was made by finding characteristic cerebrospinal fluid changes, marked lethargy, irritability and other common signs of the encephalitides. These cases occurred during the poliomyelitis epidemic and in some cases in the same family as other children who had other forms of poliomyelitis. These considerations made the diagnosis of polioencephalitis more probable than any other type of encephalitis, although it was realized the diagnosis could not be absolutely confirmed except by means not at our disposal. There were four of these, constituting 3.9 per cent of all.

Of this group case No. 32 is fairly typical. A 3-year old white girl was brought to the hospital because of headache, fever, and vomiting of one day's duration. Examination showed a very lethargic and disoriented child with only slight stiffness of her neck and back. There was complete absence of tendon reflexes. The cerebrospinal fluid contained 80 cells per cu. mm., 60 per cent of which were lymphocytes. The globulin test was positive. The white blood cell count was 12,000. For the next three days the child was very lethargic, irritable, and exhibited fine tremors of the entire body. This gradually disappeared but there developed gradually a moderate amount of stiffness in the spinal muscles. Hot packs were applied and at the end

Table 2.

All Cases of Poliomyelitis for Year of 1945

No.	Chart No.	City	Age	Sex	Date Adm.	No. Days In Hosp.	Type*	Degree of* Paralysis
1.	55850	Irondale	5	M	5-10	11	NP	0
2.	56171	Rootstown	6	M	5-25	17	B	0
3.	56393	Rootstown	5	M	6-7	49	B & SP & ENC	0
4.	56816	Akron	11	M	6-27	27	NP	0
5.	56844	Akron	5	M	6-29	19	NP	0
6.	56920	Akron	6	M	7-4	13	NP	0
7.	56929	Mogadore	7	M	7-5	13	NP	0
8.	56931	Navarre	5	M	7-5	16	NP	0
9.	57092	Akron	4	F	7-16	11	NP	0
10.	57103	Akron	3	F	7-17	8	NP	0
11.	57147	Ravenna	11	F	7-19	40	SP	Died
12.	57170	Akron	5	F	7-22	13	NP	0
13.	57171	Barberton	9	F	7-22	31	B & ENC	+
14.	57174	Ravenna	18 Mos.	M	7-22	28	SP	++
15.	57203	Barberton	12	F	7-24	32	SP	+
16.	57237	Barberton	11	M	7-26	18	NP	0
17.	57338	Wooster	6	F	8-2	13	ENC	0
18.	57323	Clinton	8	F	8-2	49	SP	+++
19.	57352	Barberton	17 Mos.	M	8-4	31	SP	+
20.	57391	Akron	11	F	8-7	123	SP	+++
21.	57419	Barberton	2	F	8-10	29	SP	+
22.	57422	Akron	6	F	8-10	20	NP	0
23.	57463	N. Lawrence	3	F	8-13	48	SP	0
24.	57464	Akron	7	F	8-13	35	NP	0
25.	57465	Akron	6	M	8-14	20	NP	0
26.	57469	Akron	4	F	8-14	20	NP	0
27.	57484	Akron	8	M	8-16	27	NP	0
28.	57498	Wadsworth	5	M	8-17	58	SP	++
29.	57509	Doylestown	7	M	8-18	32	NP	0
30.	57513	Beloit	7	M	8-19	134	SP	+++
31.	57540	Ravenna	14	M	8-22	4	NP	0
32.	57554	Barberton	3	F	8-23	28	ENC	0
33.	57556	Akron	6	F	8-24	19	NP	0
34.	57589	Barberton	7	M	8-27	126	SP	++
35.	57590	Akron	2	M	8-27	12	NP	0
36.	57595	Homerville	12	M	8-27	35	SP	0
37.	57598	Akron	14	M	8-27	93	B & SP	++
38.	57602	Akron	9	M	8-27	23	ENC	0
39.	57620	Copley	2	F	8-29	73	SP & B	++
40.	51623	Brady Lake	16	M	8-29	124	SP	+++
41.	57644	Akron	2	F	8-31	10	NP	0
42.	57646	Barberton	14	M	9-1	37	SP	+++
43.	57649	Wooster	5	F	9-1	41	SP	0
44.	57654	Akron	5	M	9-1	17	NP	0
45.	57659	Mantua	4	M	9-2	39	NP	0
46.	57661	Akron	6	M	9-2	53	B	0
47.	57672	Akron	5	M	9-3	37	B	0
48.	57682	Barberton	12	F	9-4	78	NP	0
49.	57701	Akron	6	F	9-6	39	NP	0
50.	57702	Barberton	7	F	9-6	4	B & ENC	Died
51.	57714	Akron	10	M	9-7	25	NP	0
52.	57719	Barberton	6	M	9-7	11	NP	0
53.	57720	Akron	7	M	9-7	47	NP	0

*NP—Non-paralytic
SP—Spinal
B—Bulbar

Enc—Encephalitic
*0—No paralysis
+—Slight paralysis

++—Paralysis only one limb
+++—Paralysis more than one limb
See text for details

TABLE 2 (continued)

ALL CASES OF POLIOMYELITIS FOR YEAR OF 1945

No.	Chart No.	City	Age	Sex	Date Adm.	No. Days In Hosp.	Type*	Degree of* Paralysis
54.	57723	Akron	7	M	9-8	12	NP	0
55.	57724	Mantua	6	F	9-8	13	NP	0
56.	57731	Akron	5	F	9-9	29	NP	0
57.	57759	Mantua	10	F	9-11	100	B & SP	+
58.	57761	Akron	9	M	9-11	30	NP	0
59.	57766	Alliance	8	M	9-12	5	NP	0
60.	57768	Akron	6	M	9-12	14	NP	0
61.	57777	Akron	7	F	9-13	70	ENC	
							B & SP	+++
62.	57787	Akron	4	M	9-14	5	NP	0
63.	57793	Lisbon	5	F	9-14	22	NP	0
64.	57795	Akron	14	M	9-15	1	B & ENC	Died
65.	57798	Barberton	7	M	9-15	17	NP	0
66.	57808	Barberton	6	M	9-16	23	NP	0
67.	57812	Barberton	5	F	9-17	20	NP	0
68.	57827	Cuyahoga Falls	8	M	9-17	25	NP	0
69.	57836	Akron	6	F	9-19	58	SP	0
70.	57838	Akron	6	M	9-19	59	NP	0
71.	57844	Newton Falls	4	M	9-19	16	SP	+
72.	57874	Newton Falls	4	M	9-22	19	SP	0
73.	57880	Spencer	3	M	9-23	99	SP	++
74.	57881	Portage Lakes	8	F	9-23	37	SP	+
75.	57890	Kent	16	F	9-24	58	SP	+
76.	57898	Garretsville	10	M	9-24	10	NP	0
77.	57909	Barberton	10	M	9-26	27	ENC	0
78.	57912	Cuyahoga Falls	17	F	9-26	41	B & SP	0
79.	57950	Akron	11	M	9-29	22	NP	0
80.	57963	Akron	6	F	10-1	92	SP	+++
81.	58027	Akron	4 Mos.	F	10-8	12	NP	0
82.	58037	Newton Falls	12	M	10-8	15	NP	0
83.	58055	Massillon	9	M	10-10	31	NP	0
84.	58062	Akron	4	M	10-10	82	SP	++
85.	58068	Akron	6	M	10-11	28	SP	+
86.	58106	Uniontown	15	M	10-14	4	ENC	
							B & SP	Died
87.	58118	Cuyahoga Falls	6	F	10-15	70	ENC & SP	+++
88.	58125	Smithville	19 Mos.	M	10-15	80	SP	+
89.	58129	Toronto	11	M	10-15	68	SP	0
90.	58141	New Philadelphia	15	F	10-16	70	SP	+++
91.	58154	Akron	8	F	10-16	51	SP	0
92.	58171	Barberton	6	M	10-17	78	SP	+++
93.	58189	Akron	13	F	10-19	30	NP	0
94.	58214	Toronto	4	M	10-20	10	SP	++
95.	58256	Dalton	14	F	10-23	69	SP	+++
96.	58319	Lodi	8	M	10-28	39	NP	0
97.	58408	Cuyahoga Falls	16	M	11-2	60	B & SP	+
98.	58452	Akron	14	F	11-4	58	NP	0
99.	58490	Wooster	12	F	11-6	55	SP	++
100.	58495	Akron	7	F	11-6	30	SP	0
101.	58701	Akron	3	M	11-18	43	SP	++
102.	58955	Portage Lakes	14	F	12-3	28	SP & B	+++
103.	59163	Akron	8	M	12-14	17	NP	0

*NP—Non-paralytic
SP—Spinal
B—Bulbar

Enc—Encephalitic
*0—No paralysis
+—Slight paralysis

++—Paralysis only one limb
+++—Paralysis more than one limb
See text for detai.s

Table 3. Classification of Types of Involvement

Form of Disease	No. of Cases	Per Cent of Total
Non-paralytic	49	47.6
Spinal	34	33.0
Encephalitic	4	3.9
Bulbar	3	2.9
Combination	13	12.6

of 28 days the child was completely improved and discharged.

Another case of this group developed diplopia that disappeared after 10 days. Another developed respiratory difficulty and a Babinski sign that improved after one day.

4. Bulbar Type. In this group are included cases showing the lower motor neuron type of paralysis involving cranial nerves, the commonest of which were the 9th and 10th. Three cases or 2.9 per cent of the total were of the pure bulbar variety.

Case No. 47 is typical of the bulbar type of poliomyelitis. A five-year old white boy was brought to the hospital with a history of fever and "intestinal flu" of four days' duration. He had difficulty in swallowing, thickness of speech for three days, and had been treated at home with sulfadiazine. Examination showed absent pharyngeal reflexes, considerable tightness of nuchal, spinal, and hamstring muscles. Cerebrospinal fluid examination confirmed the diagnosis of poliomyelitis. Treatment was symptomatic and hot packs were used for muscle tightness. Recovery was gradual and complete after 37 hospital days.

5. Combination Type. This consists of a group of 13 patients showing combinations of the spinal, bulbar, and encephalitic forms. These were the most serious of all from the point of view of mortality and extent of paralysis. Of these, 6 were of the bulbospinal type, 3 showed signs of spinal, bulbar and encephalitic involvement, 3 were encaphalitic and bulbar combinations, and one showed evidence of spinal and encephalitic involvement. This group constituted 12.6 per cent of the total.

Case No. 61 is typical of a patient showing a combination type of involvement. This 7-year old white boy was admitted with a history of difficulty in swallowing solids, pain in his neck and shoulders, of two days' duration. He had vomited frequently the day before admission. Examination revealed considerable tightness of neck, back and hamstring muscles. Pharyngeal reflexes were absent and there was no apparent muscle weakness. Cerebrospinal fluid contained 44 cells per cu. mm., 72 per cent of which were lymphocytes. The globulin test was positive. The white blood cell count was 12,100.

For the first three days the child was extremely lethargic and difficult to arouse. He developed a right Babinski sign. Dysphagia continued for at least a week during which time nourishment was given mostly by gavage or parenterally. During the first week there developed marked weakness of all muscles of both shoulders and of the anterior neck muscles. There also appeared marked weakness of all muscles in the right lower limb and a lesser amount, in muscles of the left lower limb. There was gradual diminution of muscle spasm and he was discharged at the end of 70 days. He was still not prepared to get about even with the aid of braces and to a great degree his disability on discharge appeared likely to remain permanently.

Of the remaining cases in this group, there were three deaths. In all of these, death was due to respiratory failure due to involvement of the respiratory center. Two lived four days after admission, and one only eight hours. In two, there were other signs of bulbar involvement. One case was comatose on admission and developed an upper motor neuron facial palsy. Two other cases showed facial paralysis and three developed bladder paralysis. In one, due to the presence of a retention catheter which was inserted in another hospital, a cystitis developed which persisted for one month. In all cases, however, there was complete return of bladder function without any complications.

Frequency of Presenting Signs and Symptoms

Table 4 shows in order of frequency the presenting symptoms, and the findings on physical examination. It is seen that the commonest symptoms were fever, headache and gastro-intestinal disturbances, such as nausea, vomiting, and abdominal pain. Symptoms referable to the muscular and nervous systems were not nearly as frequent.

Table 4. Physical Findings and Symptoms in Order of Frequency

Physical Findings in Order of Frequency	Symptoms in Order of Frequency
Nuchal and spinal rigidity	Fever
Spasm of hamstrings	Headache
Muscle weakness	Gastro-intestinal disturbances
Muscle paralysis	Muscle weakness
Absent abdominal and tendon reflexes	Back pain
Absent pharyngeal reflexes	Back and neck stiffness
Lethargy	Muscle pain
Thick type of speech	Back and neck pain
Facial nerve paralysis	Dysphagia
Distended bladder	Lethargy
	Pharyngitis
	Dysarthria
	Facial paralysis
	Chills
	Convulsions
	Bladder paralysis

It was also noted that evidence of muscle weakness or paralysis, absence of abdominal and tendon reflexes did not occur as frequently as did the common findings of rigidity of the nuchal, spinal and hamstring muscles. For this reason, every child with fever, headache, or

gastro-intestinal upset who on physical examination showed nuchal, spinal or hamstring rigidity, no matter how slight, was suspected of having poliomyelitis until disproved, either by examination of the cerebrospinal fluid or in some other way.

LABORATORY FINDINGS

In each acute case the cerebrospinal fluid was examined. An analysis of those showing increased cell counts is shown in Table 5. Most patients had counts less than 100 cells per cu. mm. and only 6 per cent had counts over 500 cells per cu. mm. The highest number of cells found was 840, and the lowest was 11. No correlation whatsoever could be found with the number of cells in the cerebrospinal fluid and the extent of paralysis.

TABLE 5. ANALYSIS OF CEREBROSPINAL FLUID FINDINGS AND WHITE BLOOD CELL COUNTS IN ACUTE CASES

Cerebrospinal fluid cell count per cu. mm.	Percentage Incidence	White blood cell count per cu. mm.	Percentage Incidence
10-100	60	5-10,000	70
100-500	34	10-15,000	24
500 and over	6	15,000 and over	6

Analysis of the white blood cell counts as seen in each acute case is also shown in Table 5. A leucocytosis in a patient with poliomyelitis was found to be relatively uncommon.

EXTENT OF RECOVERY

Table 6 shows extent of recovery in all cases. As the degree of final recovery can not be judged until two years have elapsed since the onset of the disease, our figures will necessarily tend to be conservative. On the other hand, in some cases hitherto undetected muscle weakness may manifest itself only after the patient has experienced further weight bearing and more exercise than was accustomed in the hospital. For this reason our findings at the time of hospital discharge should not be regarded as the final state resulting from this disease and its treatment. It was believed, however, that it was possible at this time to form a reliable estimate of the degree of recovery and the amount of paralysis sustained in this epidemic. All cases that were discharged and those remaining in the hospital after December 31, 1945, were classified into the following five main groups.

1. In the group indicated by 0 in Table 6 are included all cases in which no muscle weakness or paralysis was noted. Also included are those who on discharge showed unimpaired use of all extremities, but slight weakness of some muscle groups that were noted only after careful muscle examination. There were 66 cases in this group constituting 64 per cent of all. Forty-nine of these cases were from the non-paralytic type of poliomyelitis and there were only 17 in this group from the remaining 55 cases. In other words, if the group of non-paralytic cases is not considered, only 17 cases or 30.9 per cent of the other forms of poliomyelitis recovered with no paralysis.

2. In the group marked + are included cases with good functional use of all muscles, but with some noticeable weakness in one or more groups that is easily detectable, but not severe enough to constitute a handicap to the patient. It is from this group that further improvement can be expected to produce complete recovery. There were only 11 of these, constituting 10.7 per cent of all cases.

TABLE 6. DEGREE OF RECOVERY IN EACH TYPE OF CASE

Form of Disease	Involvement* 0	+	++	+++	Died	Total
Non-paralytic	49	0	0	0	0	49
Spinal	8	8	8	9	1	34
Bulbar	3	0	0	0	0	3
Encephalitic	4	0	0	0	0	4
Combination	2	3	2	3	3	13
Total	66	11	10	12	4	103
Percentage of Total	64	10.7	9.7	11.7	3.9	

0—No paralysis
+—Slight paralysis
++—Paralysis only one limb
+++—Paralysis more than one limb

3. In the group marked ++ are patients with severe paralysis of part, or of an entire extremity to the extent that braces or surgery may be necessary. There were 10 of these, constituting 9.7 per cent of all.

Of these patients 8 were of the pure spinal variety, and the other 2 of the bulbospinal type. In 8 there was sufficient weakness in one or other of the lower limbs to require braces or future surgery to enable the child to get about well. In the remaining 2 there was paralysis of one upper limb sufficient to constitute a disability.

4. In the group marked +++ are those with severe paralysis of muscles in more than one extremity where there was sufficient impairment to require surgery or braces. There were 12 of these or 11.7 per cent of all. Nine of these patients had pure spinal involvement, and the other 3 had spinal paralysis combined with either the bulbar or encephalitic forms of poliomyelitis. In 5 of these, there was marked weakness of the lower limbs together with a lesser degree of weakness of the upper limbs. Four patients developed almost complete paralysis of both lower limbs. Two cases had almost complete paralysis of both upper limbs, and the remaining case had marked weakness of all upper limb muscles as well as considerable weakness in muscles of both lower limbs. The latter

case showed the greatest amount of paralysis of any in this epidemic.

5. In this group are the cases that died. There were 4 deaths, making a mortality rate of 3.9 per cent. All deaths were due to respiratory failure. Three were in patients with severe bulbar and encephalitic involvement and the fourth in a patient with severe spinal involvement. In the latter there was extensive weakness of all the muscles concerned with respiration and death was due, as determined by autopsy, to an obstructing plug of mucus lodged in the lower end of the larynx.

To summarize the above, it is seen that there were 37 patients in this epidemic who were permanently affected in one way or another. These constituted 36 per cent of the total.

EFFECT OF TONSILLECTOMY ON TYPE OF INVOLVEMENT

Because of the much discussed relationship of recent tonsillectomy to the bulbar type of poliomyelitis,[3, 4] the presence or absence of tonsils was noted in each case. No patient had had a tonsillectomy within 90 days of admission, and the majority of those who had a previous tonsillectomy had them removed one or more years before the development of poliomyelitis. There has been little emphasis in the recent literature of the relationship between non-recent tonsillectomy and the subsequent development of a particular type of disease. For this reason the facts brought out by this study in our patients are interesting.

Table 7. Relation of Previous Tonsillectomy to Type of Involvement

Form of Disease	No. of Cases	No. cases with previous Tonsillectomy	Per cent cases with previous Tonsillectomy
Non-paralytic	49	16	33
Spinal	34	9	30
Bulbar	3	3	100
Encephalitic	4	1	25
Combination	13	10	77

As shown in Table 7 a minority of the patients who developed non-paralytic, spinal, or encephalitic forms of the disease, had had previous tonsillectomies. Three who had the pure bulbar form, with involvement of the 9th and 10th cranial nerves, did have previous though not recent tonsillectomies. Of the 13 patients classified as having a combination form of the disease, 12 exhibited evidence of bulbar involvement. Of these only 10 showed involvement of the 9th and 10th cranial nerves, those involved mostly in swallowing and speaking. Among these 10, 9 patients had had a previous tonsillectomy. In other words, out of 15 patients who had signs of bulbar poliomyelitis, 13 showed signs of involvement of the 9th and 10th nerves and of these, 12 had had at one time or another a tonsillectomy.

Our small number of cases makes it impossible to draw definite conclusions, but further and more extensive observations on this subject certainly appear to be indicated. Although it has been generally accepted that recent tonsillectomy favors the development of the bulbar type of poliomyelitis,[5] our experience raises the question whether tonsillectomy performed at any time previously will also tend to favor a bulbar form of disease. Similar experiences have been reported elsewhere.[6, 7, 8] How and whether the presence of tonsillar and adenoidal tissue can prevent the use of the nasopharynx as a portal of entry for the poliomyelitis virus, is a question for future study.

DURATION OF ILLNESS BEFORE ADMISSION

An analysis was made in each acute case, of the duration of symptoms before the commencement of therapy. Table 8 indicates the average duration of symptoms in each type of case.

Table 8. Duration of Illness before Admission

Form of Disease	Average duration of Illness before admission
Non-paralytic	2.4 days
Spinal	5.1 "
Bulbar	3.7 "
Encephalitic	1.8 "
Combination	4.3 "

The average for the total number of acute cases was 3.6 days. It is surprising that in what is usually considered a self-limiting disease that patients with the earliest diagnosis and the earliest institution of therapy, were the ones that developed the mildest forms of the disease. Table 9 shows this even more clearly, where the average duration of illness in the severe and milder forms of the disease is compared.

Table 9. Relation Between Duration of Illness and Extent of Involvement

Extent of involvement	Average duration of Illness before admission
0	2.8 days
+	2.8 "
++	6.3 "
+++	6.0 "
Died	3.5 "

It was seen that the cases showing the more severe forms of paralysis were the ones that remained undiagnosed longest, and that the ones with maximum recovery, were the ones with the shortest duration of illness before

commencement of therapy. Here again we would not be justified in drawing any final conclusions and further observation and study of this time factor appears desirable. In all fairness, however, it must be noted that there were 7 patients who on admission showed no evident muscle weakness, and who in spite of early treatment, proceeded to develop varying degrees of paralysis, some of these being quite debilitating.

LENGTH OF HOSPITAL STAY

In Table 10 is shown the average length of hospital stay of each patient. This was 37.9 days. As there were still 15 patients in the hospital at the time this report was written, only the number of days they spent up to December 31, 1945, was considered. Some of these will require hospitalization for some time yet and this will tend to raise the average case hospital stay still further.

TABLE 10. AVERAGE NUMBER OF DAYS IN HOSPITAL PER CASE

Form of Disease	Total No. of Cases	Total No. Days in Hospital	Average No. Days in Hospital
Non-paralytic	49	1112	22.7
Spinal	34	1978	58.2
Bulbar	3	107	35.7
Encephalitic	4	91	22.8
Combination	13	624	48.0
Total	103	3912	37.9

These figures again suggest that from a purely economic viewpoint early institution of treatment is helpful in reducing hospital stay. The non-paralytic forms of poliomyelitis were able to go home in almost one-third of the time taken by the more severe forms.

SUMMARY AND CONCLUSIONS

1. An analysis was made of 103 cases of poliomyelitis that were admitted for treatment to the Children's Hospital, Akron, Ohio, during 1945.

2. The majority of cases were admitted during September and October, and although cases from 4 months to 17 years of age were seen, the majority were between the ages of 4 and 8. No relation between the atmospheric relative humidity and mean daily temperature was noted. The peak of the epidemic took place at the time of ripening of most fruits in this area.

3. A uniform method of hot pack therapy was carried out in all cases and passive and active motion was instituted as early as possible.

4. All cases were classified as non-paralytic, spinal, bulbar, encephalitic, and combination forms. Figures were given to represent the number in each group.

5. An analysis of the presenting signs and symptoms of all patients was made. It was found that fever, headache, and gastro-intestinal disturbances were the early symptoms. The early findings were nuchal, spinal and hamstring rigidity. Evidence of muscle weakness was a late finding.

6. Summary was made of pertinent laboratory findings.

7. On discharge from hospital, patients were classified according to degrees of involvement, into five main groups. Analysis was made of cases in each group; 64 per cent of all cases were discharged with no paralysis. However, if the group of non-paralytic cases were to be excluded, only 30.9 per cent of the paralytic forms recovered without paralysis. Ten and seven-tenths per cent had a minimal amount of paralysis, not constituting a handicap and likely to improve. Nine and seven-tenths per cent had enough paralysis in not more than one limb, to require braces or possibly future surgery. Eleven and seven-tenths per cent had paralysis of a debilitating nature involving more than one limb, and 3.9 per cent died.

8. Twelve out of thirteen patients exhibiting involvement of the 9th and 10th cranial nerves had previous, but not recent tonsillectomies. Only 30 per cent of patients with other forms of involvement had previous tonsillectomies. The question must be asked whether there is any relation between a non-recent tonsillectomy to the type of poliomyelitis.

9. Analysis of the duration of symptoms in all acute cases before admission was made. The average was 3.6 days. However, the average in the non-paralytic forms was found to be less than half the average of the cases that displayed paralysis.

10. Analysis was made of the average hospital stay per patient. This was found to be 37.9 days. The non-paralytic forms were able to go home in almost one-third of the time taken by the more severe forms.

BIBLIOGRAPHY

1. Toomey, J. A., August, M. H.: Poliomyelitis. Amer. Jr. of Dis. of Children, 46:262, 1933.

2. Toomey, J. A.: Poliomyelitis. Jr. of Ped., 19:103, 1941. 1941.

3. Sabin, A. B.: Experimental Poliomyelitis by the Tonsillopharyngeal Route. J.A.M.A., 111:605, 1938.

4. Stillerman, M., Fischer, A. E.: Acute Bulbar Poliomyelitis following recent Tonsillectomy and Adenoidectomy. Amer. Jr. of Dis. of Children, 56:778, 1938.

5. Francis, T. Jr., Krill, C. E., Toomey, J. A., Mack, W. N.: Poliomyelitis following Tonsillectomy in Five Members of a Family. J.A.M.A., 119:1392, 1942.

6. Eley, R. C., Flake, C. G.: Acute Anterior Poliomyelitis Following Tonsillectomy and Adenoidectomy. Jr. of Ped., 13:63, 1938.

7. Fischer, A. E., Stillerman, M., Marks, H. H.: Relation of Tonsillectomy and of Adenoidectomy to the Incidence of Poliomyelitis. Am. Jr. of Dis. of Children, 61:305, 1941.

8. Lucchesi, P. F., LaBoccetta, A. C.: Relation of Tonsils and Adenoids to the Type of Poliomyelitis. Am. Jr. of Dis. of Children, 68:1, 1944.

Rupture of the Uterus

ANTHONY H. DINDIA, M.D., and VINCENT J. TURCOTTE, M.D.

RUPTURE of the uterus is one of the most serious complications of obstetrics since the lives of both the mother and the child are endangered. Hence this emergency calls for sound judgment and rapid surgical intervention. Tears of the body of the uterus and of the cervix usually follow the manual dilatation of the cervix; in uteri previously subjected to a classical Cesarean section; after the employment of internal podalic version in neglected or mismanaged cases; and the indiscriminate use of pituitrin to induce or hasten labor. The latter cause is perhaps the least justifiable since in the great majority of incidences the rupture can be prevented.

The reported incidence of rupture of the uterus varies considerably. Irving[1] states that rupture of the uterus has been treated once in every 1,959 deliveries at Boston Lying-In Hospital. Stander[2] reports one in every 2,260 labors at New York Lying-In Hospital, and Bill[3] reports one in every 2,756 deliveries at University Hospital in Cleveland. Many cases undoubtedly are not reported as some are not diagnosed, while others are disposed of without postmortem examination, the death then being attributed to postpartum hemorrhage, embolism, massive collapse of the lungs, and shock.

In a survey of several Detroit hospitals a number of ruptured uteri occurred in a relatively short period of time, and these cases furnish the subject of the following report.

CASE REPORTS

Case 1: Mrs. R., aged 30, was admitted to the hospital on March 27 because of labor pains. The patient was a gravida IV and para III at term. Physical examination revealed the presenting part to be high and the position L.O.A. Pelvic measurements were normal. Twenty hours after admission the patient was fully dilated and she was taken to the delivery room. She was given 3 minims of pituitrin and, after 10 minutes, low forceps were used to deliver a living baby girl. A considerable amount of blood was lost in the delivery room. The patient was taken to her room in good condition. One hour following delivery the patient became cold, clammy, and perspired profusely; she complained of lower abdominal pain, and the pulse was imperceptible. She was given oxygen, ephedrine, and 500 cc. of plasma. After the mother delivered, she was seen by two consultants who did not make a diagnosis. The patient expired four-and-one-half hours following delivery. Postmortem examination revealed about 1,400 cc. of bloody fluid and clots in the abdominal cavity. The uterine wall was firm and the fundus extended about 16 cm. above the symphysis pubis. A transverse laceration measuring 14 cm. in length was present in the lower uterine segment and a large hematoma was noted under the serosal layer in the anterior surface of the uterus (Fig. I).

From the Department of Obstetrics and Gynecology, St. Mary's Hospital. Submitted January 24, 1946.

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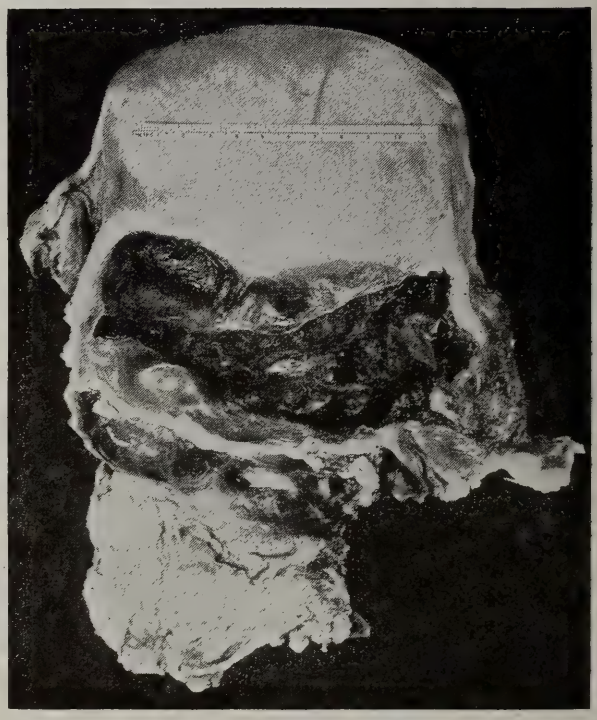


FIG. I

Case 2: Mrs. L., aged 38, was admitted to the hospital on September 15. The patient was a gravida IV and para IV at term. The membranes had been ruptured four hours previously. The head was high, no dilatation, and the position was L.O.A. Pelvic measurements were adequate. Shortly after admission she began to have irregular weak contractions. Since she was not in active labor 4 doses of 3 minims of pituitrin were given in a period of four hours.

After the third dose of pituitrin, the patient went into active labor. Five hours after the first dose of pituitrin was instituted, the patient complained of severe abdominal pain and it was noted that there was some vaginal bleeding. The patient went into shock; pulse, blood pressure and fetal heart tones were unobtainable. Abdominal examination revealed the fetus within the peritoneal cavity. One hour following the rupture of the uterus, the patient recovered from shock and was taken to the operating room for laparotomy under local anesthesia. The peritoneal cavity contained 2,000 cc. of bloody fluid. A dead infant was found lying in the left side of the peritoneal cavity. There was a rent measuring 12 cm. in length in the anterior wall of the lower uterine segment of the uterus, a little to the left of the midline. The uterine rent was sutured. During the operation the patient received 500 cc. of blood. The patient made an uneventful recovery.

Case 3: Mrs. A., aged 31, was admitted to the hospital on October 4. The patient was a gravida VII and para VI at term. The membranes had been ruptured one hour. The head was high, no dilatation, and the position was L.O.A. The patient was not in labor. Twelve hours after admission, pituitrin was instituted because the patient failed to go into labor. She was given 3 minims of pituitrin every half-hour for four doses and at the end of this period the patient was having uterine contractions every five minutes. The contractions only lasted about one hour and the patient failed to make any progress. Ten hours after the first dose of pituitrin was given another attempt to induce labor was made. The patient was given four more doses of 3 minims of pituitrin. The contractions became effective and the patient went into active labor. She was given scopolamine and demerol for analgesia. Twenty-four hours after the first attempt to induce labor, the patient began to complain of severe lower abdominal pain. She became cyanotic, dyspneic and there was a moderate amount of vaginal bleeding. At this time she was fully dilated and a stillborn male infant was delivered with outlet forceps. Shortly after delivery the patient went into shock. She was given 250 cc. of plasma, adrenalin, coramine, and oxygen. Death occurred 25 hours after the first dose of pituitrin. Autopsy revealed the uterus to be enlarged, measuring 20 x 14 x 15 cm. The cervix was widely opened. The mucous membrane and the entire wall of the cervix were deeply hemorrhagic. In either side of the uterus there were two longitudinal lacerations measuring 5 cm. in length, beginning at the upper edge of the cervix and extending into the lower uterine segment.

Case 4: Mrs. S., aged 38, was admitted to the hospital on October 23 because of labor pain. The patient was a gravida IV and para IV at term. The presenting part was high, no dilatation, position L.O.A. Following admission the contractions became irregular and decreased in intensity. She was given 3 minims of pituitrin at 20-minute intervals for three doses. One hour after the first dose of pituitrin she went into active labor and the cervix was 4 cm. dilated. The patient complained of severe abdominal pain and there was a moderate amount of vaginal bleeding. The patient became cyanotic, the pulse was weak and rapid. She was cold and clammy. The patient was given adrenalin, caffeine, sodium benzoate, coramine, and oxygen. The patient expired three hours after the first dose of pituitrin. Necropsy revealed the fundus to be 16 cm. above the symphysis pubis. About 1,000 cc. of blood was present in the peritoneal cavity. On examination of the uterus a large rent was noted in the left lateral anterior aspect of the uterus through which the shoulders and the thorax of a fullterm, stillborn fetus were protruding. The rent measured 12 cm. in length and it extended just medial to the left horn of the fundus to about 3 cm. distal from the lower uterine segment. A large hematoma was present over the anterior surface of the uterus which extended into the broad ligament and laterally to the pelvic wall.

Case 5: Mrs. H., aged 30, was admitted to the hospital on December 11 because of labor pains. The patient was a gravida III and para III at term. Position L.O.A., station minus one, and 2 cm. dilated. Her contractions increased in severity and frequency. She was given scopolamine and demerol. Four hours after admission a living baby girl was delivered spontaneously following a left medial episiotomy. Following delivery the patient received 1 cc. of pituitrin. The placenta failed to be delivered and a gloved hand was inserted into the vaginal vault and fundus to ascertain the cause of the delay. The placenta was located adherent to the fundus. The uterus was soft and boggy. A rent was noted in the left side of the uterus. The patient bled profusely and soon went into shock. She was given plasma and blood, and she was taken then to surgery after shock had been treated. On opening the abdomen, about 250 cc. of bloody fluid was encountered in the peritoneal cavity. Examination of the uterus revealed a rent, which extended from the lower uterine segment to the external os of the cervix. She had a total hysterectomy and the patient made an uneventful recovery.

DISCUSSION

DeLee[4] has stated that the indiscriminate use of a solution of posterior pituitary preparation is one of the four major causes responsible for the persistently high maternal and fetal death rates in the United States. He considered the use of pituitrin as a criminal act if it was administered before the delivery of the child.

Mendenhall[5] reported 87 cases of ruptured uteri due to the indiscriminate use of pituitrin, and Lynch[6] has pointed out the use of pituitrin during the first stage of labor is unquestionably an important cause of rupture of the uterus. He reported one case in his series in which the history disclosed that pituitrin had been used in the first stage of labor, but he pointed out that the practitioners are very reluctant to volunteer the information that the disaster was due to ill-advised administration of this drug.

King[7] has stated that even two minims of pituitary solution may cause difficulty. Despite the above warning, solutions of posterior pituitary preparation are still used during the first and second stages of labor in many localities throughout the country. In four of the cases

reported here it is noteworthy that pituitrin was used during the first or second stages of labor.

SUMMARY

1. Five cases of rupture of the uterus have been reported, and these cases occurred within a period of 20 months in four hospitals.
2. Four patients received injections of a solution of posterior pituitary preparations either during the first or second stages of labor.
3. In all cases the uterine tears were found in the lower segment.
4. The prognosis is influenced by the amount of time which elapses between the occurrence of the rupture and the establishment of proper treatment.

BIBLIOGRAPHY

1. Irving, F. O.: Textbook of Obstetrics, New York, 1936. MacMillan.
2. Stander, H. J.: Williams Obstetrics, New York and London.
3. Bill, Arthur H.; Barney, W. R.: Amer. Jr. of Obst. and Gyn., 47:712-717, 1944.
4. DeLee, J. B.: The Use of Solution of Posterior Pituitary in Modern Obstetrics. J.A.M.A., 115:1320-1326, 1940.
5. Mendenhall, A. M.: Ruptured Uterus, J.A.M.A., 92: 1341-1346, 1929.
6. Lynch, Frederick J.: Rupture of the Uterus, Amer. Jr. of Obst. and Gyn., 49; 514-531, 1945.
7. King, E. L.: Rupture of Uterus. Amer. Jr. of Obst. and Gyn., 49; 530, 1945.

Emphasis on Tuberculosis

Traditionally, or otherwise, it may be that health officials do not allocate sufficient time or devote sufficient energy to dealing in a practical way with the tuberculosis problem. In view of the comparative size of the problem, should we not change our point of emphasis and direct our attention more vigorously toward this disease, which, from the standpoint of health and social and economic security, assumes far greater significance than all the acute communicable diseases together? When a physician sees even a possible case of scarlet fever, he usually goes into action. Jointly with the health department, all recognized steps of prophylaxis are promptly introduced. Preventive medicine assumes a conspicuous place in his thinking. The same applies where other acute communicable diseases are suspected or diagnosed. Because of the acuteness of many of these diseases, perhaps the circumstances become more dramatic. The presence of acute and serious illness engenders a greater desire for prompt and immediate action and assistance. On the other hand, the insidious character of tuberculosis is less conducive to the same mental reactions. But the channels of infection in tuberculosis may be multiplied many more times and are far more lasting than those of acute communicable diseases. Robert E. Plunkett, M.D., Conn. State Medical Jour., January, 1944.

KEEPING UP WITH MEDICINE

HIPPOCRATES described urticaria due to mosquito bites and disturbances in the gastro-intestinal tract.

* * *

THE introduction of pure vitamins which can be administered in large amounts presents the possibility of an imbalance or even antagonism between them.

* * *

DROWSINESS, malaise, photophobia, impairment of ocular accommodations, and muscle and joint pains are encountered in patients receiving Benadryl.

* * *

UTAH and Wyoming, in spite of having a mixture of races, a widely scattered rural population, and "inadequate facilities", are among the ten states with the lowest maternal death rates in the United States.

* * *

INDIAN children are remarkable for their underheight and underweight, the health of the people is being ruined progressively, India is being devitalized perhaps to be ultimately annihilated.

* * *

THERE are hundreds of thousands of cases of diverticulosis of the colon in this country. It should be considered in every case of gastro-intestinal import.

* * *

DIVERTICULOSIS of the colon develops mostly in males of the overweight and hypertensive type as they grow older.

* * *

IN general, under primitive conditions better health prevailed than in civilized conditions. Those who live on milk, meat, and fish have no tooth decay. Neither did the Hawaiian who lived on a vegetable diet. When cereals were introduced, then came dental decay.

* * *

THE history of the enema recedes far into the past beyond the earliest recorded times.

* * *

PRIMARY cancer of the lung was a rare disease until smoking became universal.

* * *

NORMAL serum proteins are necessary for prompt and complete wound healing.

* * *

FOLIC acid is not effective in leukopenia, aplastic anemia, idiopathic agranulocytopenia, or with even deficiency anemia.—J. F.

Propagating Axillary and Subclavian Venous Thrombosis With Extension Into the Dural Sinuses and Intracerebral Veins

VIRGINIA ESSELBORN, M.D., and LEONARD J. JANCHAR, M.D.*

A FAIRLY uncommon complication of cardiac failure is thrombosis of the veins of the upper extremities and brain without any evidence of trauma or infection. The following case presents this complication.

History: A 42-year old colored female was admitted to the Cincinnati General Hospital on March 2, 1946. The patient was comatose so the history was obtained from a friend with whom she lived. She had been in good health until June, 1945, when she began to notice dyspnea on exertion and ankle edema. These symptoms increased in severity and she became orthopneic. In November, 1945, she developed cough with hemoptysis when she lay on her right side. At no time did she complain of chest pain. During January and February of 1946, she had difficulty moving her legs because of her edema. Three weeks before she came to the hospital she consulted a physician who gave her digitalis but she did not take it regularly. Six days before admission she noted pain and swelling of her entire right arm and hand, pain in the right side of her neck and head, and she became drowsy. These symptoms persisted until the day of admission. That day she developed a speech difficulty and shortly afterwards lapsed into a stuporous condition.

Physical Examination: Temperature 99.4°; pulse 92; respirations 30; blood pressure 145/100 in both arms. The patient was a well developed, middle-aged female who was dyspneic, orthopneic, and did not respond to any but painful stimuli. The skin was warm and moist. There were five or six ecchymoses about 2 mm. in diameter on the dorsum of the right hand and on the right anterior costal margin. The neck was supple. The left external jugular was markedly distended. The right external and internal jugular veins and the right subclavian and axillary veins were palpable as hard cord-like structures as far as they could be palpated. No pulsations could be detected in the right carotid or temporal arteries. The thyroid gland was not palpable. The trachea was in the mid-line and there was no tracheal tug. One observer noted a pulsation in the suprasternal notch.

There was marked edema of the right hand and arm which pitted on pressure. The temperture of this extremity was not different from any other part of the body. The radial pulse was a little weaker than on the left but was of good quality. The right breast was edematous and there was pitting edema of the entire thorax. The veins of the right hemithorax were distended but not thrombosed. The chest findings consisted of dullness to percussion and fine, moist rales at both bases. Breath sounds were diminished at the right base. The heart was enlarged to the left. There was a gallop rhythm. The abdominal wall was edematous. The liver edge was palpable 2 cm. below the costal margin, was smooth, firm and tender. There was pitting sacral edema. The femoral and dorsalis pedis pulses were of good quality. Both legs were markedly edematous. Neurological examination revealed small fixed pupils, right corneal reflex present but greatly reduced, left corneal reflex normal and slightly reduced, right biceps and triceps.

Laboratory Data: Hemoglobin 9 gms.; red blood cells 3,560,000; white blood cells 9,250; differential 88 per cent polymorphonuclear cells. The urine contained 4-plus albumin and an occasional white and red blood cell. The blood urea nitrogen was 16 mgm. per cent. The carbon dioxide combining power was 35.2 vols. per cent and the prothrombin time was 16 seconds. The blood Kahn was negative. Lumbar puncture was done on admission. The initial pressure was 130 mm. H_2O. The fluid was water clear and contained 78 red blood cells and 1 white blood cell. Protein was 50 mgm. per cent and the Wassermann was negative. Roentgenogram of the chest showed bilateral pulmonary congestion, fluid at the right base and a markedly enlarged heart of aortic configuration. There was no evidence of an aneurysm. Electrocardiograms were read as follows: On 3-6-46, auricular tachycardia and 2:1 block; and on 3-7-46, sinus tachycardia and 2:1 block of variable degree probably due to digitalis.

Course in Hospital: The patient was in the hospital 6 days. Because of the severe degree of congestive failure and because it was known that the patient had taken only a small amount of digitalis, she was digitalized by a rapid method. Anti-coagulant therapy consisting of heparin and dicoumarol was employed in an attempt to prevent further extension of the thromboses. In addition, the patient was given continuous oxygen from a mask, diuretics, and tube feedings with vitamins.

Throughout the hosptal stay her level of awareness was fluctuant. There were periods of short duration in which she attempted to answer questions, obeyed commands, and recognized her friends. These alternated with periods when she was comatose. Most of the time she lay with head and eyes turned to the left. In the early morning of the fifth hospital day, her blood pressure fell to 125 systolic and the diastolic could not be obtained. The right arm became cold and there was profuse diaphoresis. Later in the day she recovered somewhat, the blood pressure rose to its previous reading and she attempted to speak. Shortly thereafter she developed a flaccid paralysis of the right arm. Subsequently, the paralysis disappeared and she recovered the use of the right arm but later in the day the paralysis returned. The following morning the level of consciousness rose to the highest yet noted and the paralysis was gone. Towards evening there was again a profuse diaphoresis and coolness of the right arm. Acute pulmonary edema developed and the patient expired. Another lumbar puncture was done at this time. The fluid was clear and contained no red blood cells.

*The authors represent respectively the Medical and Pathological Services of the Cincinnati General Hospital.

This is the twenty-seventh of a series of "Case Records Presenting Clinical Problems" selected by Richard S. Austin, M.D., Professor of Pathology, University of Cincinnati College of Medicine.

Necropsy: The necropsy was performed 3 hours after death. There was pitting edema of the right arm and both legs and a few areas of ecchymoses were present in the left antecubital fossa.

The right axillary, subclavian, innominate and external and internal jugular veins were occluded with organizing and organized thrombi. The thrombus in the right innominate vein terminated 1 cm. proximal to its junction with the left innominate vein. The right jugular bulb, sigmoid and transverse sinuses contained moderately firm brownish-red thrombus loosely adherent to the intima. There was extension into the straight sinus and the veins of Galen. The superior sagittal and left dural sinuses were markedly distended with fluid blood but contained no clots.

The brain weighed 1,325 gms. The superficial veins were markedly congested but intact. The cerebral arteries were patent but slightly sclerotic. There was no thrombus in the intracerebral portion of the right and left internal carotid arteries. The external surface of all the lobes appeared normal. Cononal sections through the brain at 1.5 cm. thicknesses, revealed multiple punctate hemorrhages and areas of grayish-brown softening scattered throughout the basal ganglia, internal capsule and caudate nucleus bilaterally radiating into the adjacent swollen white matter. The veins of Galen were distended and filled with firm brownish-red thrombus.

The pons and medulla were normal but in the right cerebellar lobe, there was an area of hemorrhagic softening 2 x2 cm. in diameter. There was no indentation of the unci of the temporal lobes by the tentorium of the cerebellum and no cerebellar pressure cone was present.

The epicardium was shiny and enclosed within the pericardial sac were 150 cc. of straw-colored fluid. The heart, weighing 520 gms., was hypertrophied and dilated. An organizing infarct 2 x 2.5 cm. in diameter was found in the posterior superior wall of the left ventricle. No thrombus was found in the coronary arteries but their intimal surfaces contained several soft elevated yellow plaques. Organizing mural thrombi were found in both ventricles unassociated with the infarct.

The right common carotid artery contained a brownish-yellow thrombus which commenced 1 cm. distal to its origin and terminated at the bifurcation. No thrombi were found in any of the other branches of the aorta.

The right and left lungs weighed 775 gms. and 600 gms., respectively. The right pleural cavity contained 300 cc. of serosanguineous fluid. The visceral pleurae were less translucent than normal and several fibrinous pleural adhesions were present over both lower lobes. Sections through the right lung revealed a subcrepitant, bloody, edematous tissue containing many organizing firm grayish-brown infarcts. Several of the branches of the right pulmonary artery were occluded by organizing brownish-yellow thrombi. A few sub-pleural hemorrhagic infarcts were found in the left lower lobe and friable reddish-brown clots, loosely attached to the intima, were present in the branches of the pulmonary arteries supplying these regions.

Miscroscopic Findings: Brain: Multiple petechial hemorrhages and areas of degeneration were present in the cerebellum and basal ganglia, internal capsule, and caudate nucleus bilaterally associated with thrombosis of the veins of Galen and contributory vessels. The capillaries were markedly congested. The arteries and arterioles were sclerotic but contained no thrombi.

Vascular System: Recanalized and organized thrombi were present in the axillary and subclavian veins. The thrombi in the dural sinuses, however, showed minimal organization. Focal collections of lymphocytes and plasma cells were found in the wall of the subclavian and axillary veins and dural sinuses. The common carotid artery showed no evidence of arteritis but was filled by an antemortem blood clot which was unattached to the intimal surface.

Lungs: The lungs showed hemorrhagic and organizing infarcts with organizing and organized, recanalized arterial thrombi, acute bronchitis and lobular pneumonia, marked chronic passive congestion, chronic emphysema and sclerosis of the pulmonary arterioles.

Heart: Organizing mural thrombi and marked endocardial fibrosis were present. There was marked coronary arteriosclerosis and the myocardial infarct was almost completely organized.

Principal Pathological Diagnoses: Propagating axillary and subclavian venous thrombosis with extension into the dural sinuses and intracerebral vens; multiple petechial hemorrhages and areas of degeneration in the brain; pulmonary thrombosis with multiple pulmonary infarcts; generalized vascular sclerosis; coronary arteriosclerosis with old myocardial infarct; endocardial fibrosis and mural thrombosis with probable embolic occlusion of the right common carotid artery; marked cardiac hypertrophy and dilation with evidence of congestive failure.

Discussion of Pathological Findings: It is evident that a thrombus originating in the right arm veins propagated and extended up the veins of the neck into the dural sinuses and veins of Galen to produce multiple areas of hemorrhagic softening in the brain because the thrombi in the dural sinuses showed minimal organization whereas those in the right innominate, subclavian and axillary veins were organized and recanalized. The pathogenesis of the thrombus in the right common carotid artery is not entirely clear. An embolus originating from the mural thrombus in the left ventricle, lodging at a narrow point in the artery with thrombus formation below the point of occlusion, probably is the explanation.

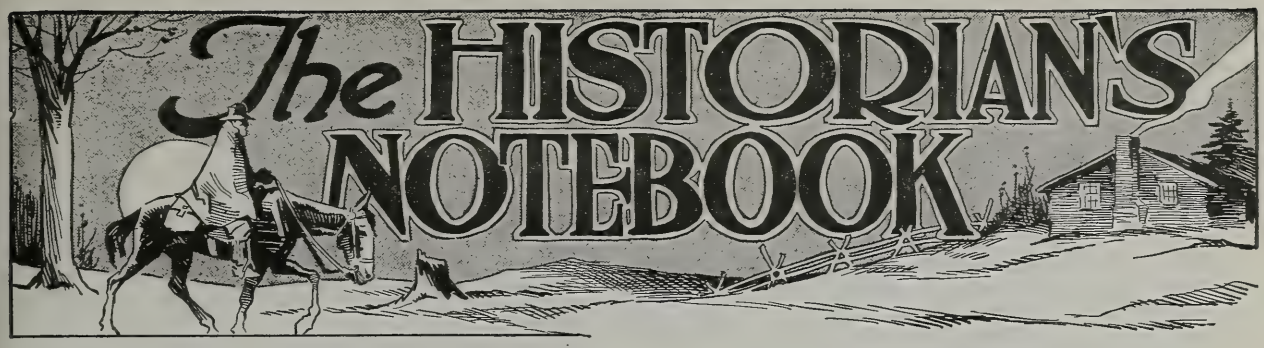
The brain lesions were very likely the immediate cause of death but with such a multitude of pathological findings, any one or a combination of them, may have been responsible.

COMMENT

This case presents an extensive propagating venous thrombosis complicating heart failure. Veal and Hussey[1] reported a series of 46 cases of subclavian and axillary vein thrombosis. Of this group, 16 were in cardiac failure due to hypertensive, syphilitic, coronary or rheumatic heart disease. In 2 of the 16 patients, the thrombosis was attributed to the intravenous injection of mercupurin and in one patient a furuncle was the cause. Autopsies were performed on 5 of the group of 16 patients, but in none was the process quite so extensive as in the case here presented.

BIBLIOGRAPHY

1. Veal, James Ross, and Hussey, Hugh: Thrombosis of the Subclavian and Axillary Veins. Amer. Heart Jr. 25:355, 1943.



Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio

Forever As He Rides

PHILIP D. JORDAN, PH.D.

A HUNDRED and eighty-eight years ago western Pennsylvania, a land deep in wood and heavy with laurel, marked the fringe of the frontier. Toward the setting, crimson sun, out beyond Fort Ligonier, scattered outposts delimited the claims of the French to the rich Ohio valley. All too frequently, shadowy figures bright with vermilion's grease, slipped stealthily to burn the miserable cabins and to plunder the hard-cleared lands of English settlers.

One bright day in 1758, the forest calm was rent with the jagged wail of bagpipes as the King's Highlanders, assisted by loyal Americans, moved stubbornly against Fort Duquesne. Slowly, beset on both flanks by Indians and French, thin lines of kilts and buckskin drove forward. When the final struggle was over, General John Forbes, a dying man, penned scrawling lines to Pitt, England's prime minister. "I have used the freedom," he wrote, "of giving your name to Fort Du Quesne . . ."

Forbes placed Colonel Hugh Mercer in command of Fort Pitt whose primitive garrison commanded the confluence of the Allegheny and Monongahela Rivers and thus guarded the gateway to the Miami country. Mercer, a Scotsman, was more than a soldier. He was a physician, a medical pioneer whose professional skill, clear foresight, and faith in the West exemplified the characteristics of hundreds of frontier doctors who were to help shape the Buckeye state and eventually to create a state medical society which now looks back upon a century of tradition and of distinguished service.

THE WINNING OF THE WEST

Gradually the British subdued other French strongholds, and in 1763 the Lion's colors theoretically waved from the broad mouth of the St. Lawrence, through the Great Lakes, down the Mississippi, and throughout the old Northwest. Doctor Mercer, within a few short years, again put aside the scapel for the sword to participate in the American Revolution as a brigadier general. With the formation of the new government of the United States of America, the western lands were thrown open to settlement for the many veterans and thousands of civilians who dreamed of the back-of-beyond as a paradise of opportunity, of equality, and of riches. To administer the Northwest Territory, Washington named Arthur St. Clair, another Scot and another physician. This shrewd, urbane, iron-willed governor won the respect of politicians and the confidence of patients.

He witnessed the first thin trickle of migration into Ohio, a trickle that within decades assumed the proportions of a deluge as generous land grants and the rapid cutting of traces and the building of roads opened the country to settlement. Soon after the turn of the century Ohio became a state and in so doing helped prepare the way for the great National Road which, with Ebenezer Zane's trace from Wheeling to Limestone on the Ohio River, was the highway of history traveled by countless physicians en route to the land of promise.

They journeyed with bell-teams tinkling, in creaking ponderous wagons; they came perched atop Conestoga schooners and in the lavish coaches manufactured at Concord, New Hampshire. They arrived in the saddle and on shank's mare. They hung out their shingles in scores of primitive villages; they crammed their

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The Author

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saddlebags with mercurial drugs and with herbs; and they watched the endless, ceaseless caravan of people pressing relentlessly westward through Ohio, to Indiana, to Illinois, and on to the shining waters of the Mississippi.

She's bounded by the Wabash,
The Ohio and the Lakes,
She's crawfish in the swampy lands,
The Milk-sick and the Shakes;
But these are slight diversions,
And take not from the joy,
Of living in this garden land,
The state of E-la-noy.

NINETEENTH CENTURY LEARNING

These early physicians, themselves emigrants, carried with them the scientific learning of the Nineteenth Century. Viewed from the vantage point of today, it was a most elementary body of knowledge. It stemmed, in large part, from the folklore of the Old World upon which was superimposed the achievements of the distinguished operators and diagnosticians of Paris, which during the middle decades was the center of European scientific thought. There in the great Parisian clinics—the Hotel Dieu, the Hospital Neckar, and La Charité—Velpeau lectured, Roux operated, and Andral demonstrated diseases of the skin.

A few early Ohio physicians had been schooled in the University of Pennsylvania School of Medicine which opened its doors in the autumn of 1765 with a distinguished faculty that four years later was to include Benjamin Rush who had just returned from study in Edinburgh. But, it is safe to say, most pioneer Buckeye doctors possessed no formal medical education. They had studied, in haphazard fashion, as an apprentice to a practitioner. "The duties of a young man so attached were numerous," writes a student of the period. "He learned to make pills, mix potions and powders, cup, bleed and do bedside nursing. Not a few of these half-fledged youths were also expected to act as sweep and stable boy for the doctor. It is conceivable that many young knights of the scalpel spent time administering grease to the master's chaise, oats to his mare, or running errands for his wife which might have been spent more profitably with a volume of Cowper's anatomy or Haller's physiology from the doctor's office, if indeed the master owned a reference library."

It was often more profitable to be preceptor to aspiring young students than to practice medicine. Dr. David Hosack, a fashionable and successful New York physician who was a member of the faculties of Columbia College, College of Physicians and Surgeons, and Rutgers Medical College, testified that he had made fourteen hundred dollars in three years by tutoring students.

Both the apprentice and the student regularly enrolled in a college course became the butt of ridicule. They were errand boys and lancet monkeys and Paul Physicks. Perhaps a very early song exposes much public opinion.

And if he attends any lectures,
It isn't because he's inclined,
But he shows himself, (once in a fortnight,)
Just to get his certificate signed;
He says he's well up in his latin,
Both Celsus and Gregory too,
But I'm sure he's a little too certain,
And I do not much think he'll get through.

He goes up to the Hall in the summer,
And so, he's beginning to read,
But he don't like his practice of Physic,
And thinks Botany humbug indeed:
He says the old saying's quite just,
Which most of you doubtless have known,
That Hydrogen means gin and water!
And Oxygen pure gin alone!!

And then comes the final warning to the ladies:

And when he has passed all his troubles,
He still from his Lady must roam,
For you know 'tis a horrid profession,
And you can't catch an instant at home;
Dear Girls, if you'll take my advice
You will never repent of the plan,
However "hard up" for an offer
Never marry a Medical man!!

FRONTIER PRACTICE

Yet if the medical man was abused as a student, he was welcomed enthusiastically in the backcountry cabin when the fever struck, when the preacher was shaking with "ager", and when the fruit of the Ohio puccoon did not banish disease. A regular physician attacked with heavy weapons: excessive blood-letting and heroric doses of calomel. He purged and puked his patient. One frontiersman described a typical course of treatment. The doctor came several miles on horseback "with his saddlebags of medicine, comprising tartar enetic, calomel, jalap, caster oil, salts . . . and a lancet. He had me thrust out my tongue for inspection, then felt my pulse. He said I was very bilious and had a high fever. He proceeded to give me an emetic, then had me take calomel and jalap for a physic. He returned two days later, found me still bad and administered more emetics and physic, and in addition bled me till I fainted and was carried to bed. He said he was 'taking me through a course of medicine to prostrate the system'. The doctor continued his remedies for about two weeks. He changed his medicines to something else . . . it made me slobber like a horse that ran on a white cloverfield. I was now reduced to a mere skeleton; life was dispaired of. But sure enough the fever was broken, for there was little left of me to create a fever."

You and I know that generally a patient's description of treatment is notoriously exaggerated and prejudiced, yet the opinion prevailed through-

out the western country that the frontier doctor was, in far too many instances, an uncouth, poorly trained empiricist who relied chiefly upon trial and error and rule of the thumb. Some pioneers disliked to call a physician, considering him a waste of both time and money. After the Supreme Court of Michigan ruled in 1838 that "a doctor is any person calling himself such," the average settler was more skeptical than ever. But it must be remembered that Michigan was not alone in this philosophy of democratic practice: Indiana had set aside all regulatory laws in 1830 and Illinois had removed fines for unlicensed practice in 1826. The natural results of such action was to throw the field of medicine wide open to quacks who rushed in to exploit the work of the adequately trained physician. And the impression has been left that the pioneer doctor was only a charlatan.

This is not the case. Respectable practitioners, knowing as much as their times permitted, fought against the lunatic fringe and labored earnestly to admit to practice men of training and of ethical character. Daniel Drake, in his address to the class of 1821 of the Medical College of Ohio, pointed the way. "Your chief ambition," he told the students, "will be to deserve the confidence of society: your greatest happiness to extend and strengthen that confidence . . . you will make science the ground work of your reputation; and acts of intelligence, honor and benevolence the material of the superstructure."

Drake was striking at the sentiments expressed by Dr. Thomas D. Witchell, of Cincinnati, in a bit of doggerel entitled "The Cobbler Turned Doctor".

> I'll purge but little; less I'll bleed,
> My plan shall be to charm;
> It may not always quite succeed,
> But then 'twill do no harm.

BEGINNINGS OF ORGANIZATION

But no one person, even such a staunch character as Drake, could by himself fight the fight. Organization was needed, and needed badly. Unfortunately, organized regulation and restraint was no common characteristic of the American frontier—whether it followed the Ohio, the Missouri, or the far-off Sacramento, the river of gold. Bickering, not cooperation, was the byword in medicine as in politics. A medical society is said to have started in Cincinnati in 1819, but it lasted less than a year. In 1824, the Ohio Legislature divided the state into twenty medical districts and stipulated that each local district should organize a society, but it was not long before the General Assembly revoked the entire plan. That was in 1833. The Fourteenth District Medical Society was typical. It came into being in 1824 and represented five counties: Richland, Huron, Lorain, Seneca, and Sandusky. By 1830 it showed signs of decay and was abolished by state enactment in 1833.

As these district societies were being formed and disbanded, smaller, local societies were increasing. A society was organized in Dayton as early as 1816; another was formed at Lebanon in 1837; a Highland County group was organized the following year; and a society begun in Summit County in 1838. A Maumee Valley Medical Association was holding meetings in the 1840's, but the city of Toledo had no organized medical group until after 1850.

It was in 1846—one hundred years ago—that the physicians of Ohio came together to organize the Ohio State Medical Society. These men were about as well acquainted with the progress of settlement and development of their profession as anyone could be in those days. In the first place, they lived, most of them, not too far from the great arteries of travel. In the south, the Ohio River flowed from Pittsburgh; through the semi-central counties ran the National Road; and in the north pulsed the steamboat traffic of the Great Lakes. And along these historic highways the destiny of a nation was being worked out. In the second place, the organizers of the Ohio State Medical Society saw the state emerge rapidly from a forest region into an agricultural community, and some doctors lived long enough to see the transformation from agriculture to commerce and manufacturing. Both the plow and the machine mean regulation and organization. It was only natural, then, that as the state became stable and mature—as it left its uncouth frontier babyhood—to settle down into a pattern of predictable living that the professions should follow suit. In part, at least, the Jacksonian doctrine of laissez-faire and of unbridled individualism was being somewhat curbed in the medical profession by the profession itself. Yet this control was not carried to the domination of the individual practitioner. It was firmly held that the best medical practice was that which was free from undue state and federal restraints. And, as a corollary, it was believed that the medical association was the agency best equipped to control its own members and its own techniques.

Historically, this regulation of medical practice by the men who practice, resulted in the stimulation of the greatest individual initiative. The liberty to know, to utter, and to argue freely—to paraphrase John Milton—helped to make the Nineteenth Century a mighty monument to the breathless progress of science and the scientific method. In anesthesia, bacteriology, modern therapeutics, preventive medicine, clinical descriptions, instruments, and modern methods of precision, as well as in the fields of physiology, asepsis, cellular pathology, and the

rise of the specialties, freedom was the Great Doctor who protected the technician bent over his microscope, watched over the clinician, and defended the men at the bedside in the ward or in the home.

FREEDOM IN PRACTICE

This freedom was the working out of the ferment of democracy, a philosophy that has given the average American the best medical care in the modern world. It is true, of course, that lack of restraint resulted in many errors and in eclecticism. Some critics have carefully colored these errors to create the impression that they were the rule and not the exception. It is equally true that critics have followed the same procedure in other fields. They have pointed to the weaknesses of the democratic system, have maintained that our economic system is only a "tightly woven system of mistakes", and have damned individualism as wasteful and corrupt. This argument, like most arguments, possesses merit if one considers small areas rather than the whole. But the fact remains that the freedom of the individual to act as an individual, so long as his actions are in accordance with the law and the spirit of the laws, has been and is the greatest motivating force in the history of American life.

The physicians of Ohio when they created the state society recognized this fact. They could scarcely escape it. It was in the very air that they breathed as they kept their office hours or rode on their calls. Many of them left their practices when the chattering telegraph keys brought the news of the firing upon Ft. Sumter in 1861. As assistant surgeons and as surgeons, they marched with McClellan, Sherman, or Grant to experience whether or not a nation could exist that was half free. Some of them were attached to the Army of the West, after Lee's surrender at Appomattox Court House, to learn at first hand of Indian warfare on the great plains, to catch the spirit of Manifest Destiny, to actually make the West safe for cowboys, sheepherders, farmers, and the thousands of foreign emigrants who flocked to the United States during the decades of the seventies, eighties, and nineties to contribute their brawn and brains, their folklore, and their loyalty to a nation dedicated to liberty and individualism.

When the army surgeon returned to the Symmes Purchase or the Western Reserve, to Cincinnati or Cleveland, he was once more a civilian who was weary of war and glad to be mustered out. He had been "nervous in the service" in those days just as he was to be in ours. And he felt in some instances that the folks at home didn't know that there had been a war. He witnessed prosperity on every hand. His patients thronged the resorts of Minnesota (Florida as a vacation land hadn't been discovered as yet) and journeyed to Saratoga Springs where greenbacks were as common as millionaires. The returning doctor, home from the march to the sea or from the Indian wars, saw the development of Big Business, and he heard the cry from populist parties for government regulation of public utilities, hours of labor, and of factory conditions. He was on hand too when the bubble of prosperity burst in the panics of 1873 and 1893.

NEW PROBLEMS AND DISEASES

The new age was both fascinating and frightening. The Buckeye doctor saw the spawning of the great cities, observed the multiplication of tenement districts, and watched the control of communities come under the corruption-stained fingers of municipal bossism and of bummers and repeaters. He was kept busy fighting typhoid fever, diphtheria, smallpox, whooping-cough, and pneumonia. In 1873, about eight hundred Ohio children died from cholera infantum; in 1880, thirteen per cent of all Ohio deaths were reported as due to consumption. Meanwhile, new diseases were being diagnosed throughout the state. A practicing physician complained that "year by year, the genius of the profession is taxed to give new names to new conditions which have arisen in this domain". He spoke particularly of the rise of mental and nervous disorders. "Railroad conductors, engineers, and other train employees," he pointed out, "show the effects of their occupation in a train of peculiar nervous systems. Telegraph operators swell the army of sufferers from nervous diseases. Sanitary measures have reduced the liability of humanity to the destructive elements of the past centuries, but the demands of modern living have introduced new factors of mortality into our social life, which are evidently not less destructive, for their influence increases year by year, and we are far from the end."

The doctor's battle was not over even though the graves were closed at Gettysburg and the Indians were being herded on to reservations. The Ohio State Medical Society supported the establishment of a State Board of Health, and by 1890 it was mandatory that cities and villages having a population of five hundred or more establish a board of health. Ohio was not the first to create such an agency. Massachusetts took the lead in 1869, California followed two years later, and Minnesota came third in 1872. In Ohio, physicians, in their buggies, rode to inspect water closets and privies, to establish quarantines, and to check on localities or houses where infectious or contagious diseases existed or were suspected to be present. The story of the public health movement in Ohio and throughout the nation is one of the most

dramatic ever to be recorded. It is a great pleasure to be able to report that the Mayo Properties Foundation recently has granted to the University of Minnesota and to the Minnesota Historical Society the sum of $25,000 to be used for research and for writing the history of the public health movement in the North Star State.

The year 1890 marked the official close of the American frontier, and, in a sense, it also delimited the end of an epoch in Ohio. No longer was the Miami country the end of the trail as it had been when General Forbes and his Highlanders wrestled Fort Du Quesne from the French. The old National Road and the network of lazy canals have been replaced by the locomotive that snorted across Ohio dragging primitive Pullmans and rococco parlor cars. Ohio now was "settled" and was considered an eastern state by thousands of Americans and hundreds of emigrants who conceived the West as the region of the trans-Mississippi—the states of Nebraska, Utah, and Wyoming. Ohio had come of age and was proudly referring to itself as the state that made presidents.

THE DOCTOR CHANGES

The doctor had changed as much as the state. The Revolutionary physician had become a legend, the frontier man of medicine was fast disappearing, and the Civil War practitioner, with his Grant beard or his burnsides, gradually was being replaced by younger men who no longer wore their needles as lapel decorations. These smart young doctors, affecting starched white jackets from whose pockets dangled a Scott Alison differential stethoscope, considered themselves the utmost in modernity. Some of them had been graduated from state universities. Many of them had interned. All of them felt themselves superior to the "old doctor". None of them knew the texts of previous decades—Eberles' *Practice of Medicine,* Colles' *Surgical Anatomy,* Dewees' *System of Midwifery.* They were scientists with a capital "S". Their office bookcase was apt to house the eight volumes of Buck's *Reference Handbook of the Medical Sciences,* a standard set published in New York in 1888. When they met together they discussed the bacteriological diagnosis of diphtheria, the Widal reaction in the diagnosis of typhoid fever, sputum examination for tuberculosis, the bacteriological examination of water, and bacteriological investigation in hog cholera and swine plague. They debated the necessity of keeping vital statistics and they argued the usefulness of vaccination.

The laboratory was coming into its own in the annals of medical progress. Sternberg's *Bacteria,* published in 1884, was the handbook upon which many of the younger men leaned heavily. Only two years earlier Robert Koch, the founder of modern bacteriology, had made the discovery of the cause of tuberculosis. Within a few years Emil von Behring, a Prussian army surgeon working in Koch's Institute in Berlin, prepared his diphtheria antitoxin.

Yet, despite the steady advances of research, medical practice advanced slowly. Some of the older men could not adjust themselves to the times, and many Ohioans resented laboratory methods because they did not understand them. Sometimes religious opinion firmly stood its ground against the results of modern science. Frequently, the immigrant, bewildered in a strange land and confused by a new language, refused to relinquish native folkways.

WIDENING FIELDS OF KNOWLEDGE

The Ohio physician of the late Nineteenth Century fortunately had at his command techniques that to many laymen were even more magical and even more powerful than ancient incantations. Gradually the public realized the magic inherent in the test tube and on the microscope's slide. By 1900, public confidence that had been lost during earlier decades of the century was returning. This renewed respect for the medical profession, it must be confessed, had to be cultivated. Medicine had to prove that it was worthy of the faith of the patient. Although the return of confidence was both slow and gradual, it did come back. That is the important point.

The Ohio physician was a part of a world movement. As he labored in a rural community, he saw more than the spring's bursting redbuds. If he possessed vision, his eye caught the reflection of scientific advances in England and on the continent of Europe. His hands duplicated techniques first demonstrated in Edinburgh, Glasgow, London, Paris, or Berlin. Buckeye medical regionalism had as its boundaries the entire world of science.

This cumulative wisdom, in realty, was the history of medicine. Its significance did not go unrecognized either in this country or abroad. In 1884, Sir J. Risdon Bennett, fellow of the Royal Society, made the inaugural address at the opening of the medical session at England's great St. Thomas's Hospital. Talking to young men about to enter medical training, Dr. Bennett said: "Leisure hours . . . will be profitably employed in learning what has been thought and done by the great men of the past. In the history of medicine you will find much to interest as well as to instruct you. Stores of wisdom are to be found in the writings of bygone observors that may be made practically available at the present time, and assistance often obtained on questions of the day by learning the errors

and mistakes, as well as the discoveries, of the past."

The public, of course, was quite unaware of the dramatic implications inherent in medical knowledge in the forty-year period from 1860 to 1900. Biological sciences and health hygiene were beginning to take their places in the curricula of secondary and higher education, but it can not be said that there was any well-developed understandng of contemporary investigation. Somehow or other the public mind had become entangled with Darwin—evolution meant monkeys to the American masses. The Ohioan with a bellyache failed to perceive, in many instances, that his old doctor was really a new doctor. The physician's carrage was the same, his battered case looked as it had for years, and his store of quips and bed-time joke had not changed or improved. He still knuckled the chest, felt the pulse, stuck a thermometer in the mouth, and said: "Stick out your tongue—farther!" The patient thought he was the same old doctor, and was certain of it when he received a supply of pink calomel pills. The patient would have been disapponted had he not received those pills! His faith primarily was in the doctor and not in science.

THE OLD VERSUS THE NEW

Perhaps this faith is expressed best of all in a little poem that first was published in the *Illinois Medical Journal* in 1905. The verses contrast the old doctor with the newer scientfic ones.

They say that young Doc Morfoot is drivin' fit
to bust;
An' Green, the homeopathy, is raisin' quite a
dust.
They're both of 'em nice fellers, so fur as I
can see,
But Ol' Doc Lent of Frogmore is good enough
for me.

I never could get used to these doctors nowadays.
With all their queer inventions an' their new-
fangled ways.
Doc says he doesn't need 'em; he's practiced
forty years
Without no patent dingus a-stickin' in his ears!

When Doc Lent comes to see you, he just hauls
up a chair,
An' feels your pulse a minute, an' sets a-starin'
there;
His black eyes borin' through you; there ain't
a single thing
A-goin' on inside you that he don't see, by jing!

There was much that the medical profession did not see and even now does not appreciate, for the facets of the social environment were changing even more rapidly than was science. The doctor, like most Americans, has not realized that the Twentieth Century is not an end in itself, but is a churning transitional period. The world of today is not the tight cosmos of yesterday—it is a distorted reflection of tomorrow's universe.

A SOCIAL REVOLUTION

A crisis of mankind has come upon us. It is deeply, *deeply*, conditioning our thinking and our way of life. Diagnosis is fairly certain; prognosis is most uncertain. But one thing seems true. The movement is in the direction of the socialized state. Just as we labeled another, earlier period the Industrial Revolution, so are we going to be forced to call the period of today, the Socialist Revolution. It matters little whether we approve or disapprove. Even if we gathered all the conservatives and dumped them into the sea, even if we collected all the radicals and consigned them to the same grave, the movement would continue. Some nations of the world are not moving, in what we always considered the normal pattern, from feudalism through capitalism to socialism, but are skipping the middle step. They are moving directly from feudalism to socialism. They may continue to do so.

The physician can not evade the historic consequences. He also is a part of social evolution. Try as he will he can not escape the destiny that is the nation's and the world's. But if we will try to participate earnestly in the world of affairs we may be able to guide the revolution toward a goal that will bring greater satisfactions and greater liberties to all concerned. The struggle for freedom and the better way of life now is under way by millions of heretofore subjugated and exploited peoples. The United States need not fear overmuch the results if it will take part in the process; if it will not withdraw from world affairs; if it will not rely upon an unreal nationalism and seek to barricade itself behind the walls of a great army and a greater navy and an even greater air force. Blind nationalism and economic isolationism will be our undoing if they characterize our foreign policy. We can not now lose what peace there is left in this shattered world by withdrawing from active, strenuous participation in the world.

Once, years ago, this nation won a frontier and sealed it with security because the men and women of the nation put their hearts and their minds to the task. Today, the American must learn new lessons and new concepts in a new manner. He must work for the ultimate success of mankind, so that man may live in peace. He must direct the revolution, so that it may be a peaceful movement and not a discordant force. It will be hard work, but it is worthwhile labor. The doctor must ride in the interests of the world, so that harmony may become as internationalized as has science itself.

O.S.M.A. Program for Home-Town Treatment of Disabled Veterans Accepted; Effective July 1; All Members Urged To Sign Up At Once

HAVING received the full approval of the U. S. Veterans Administration, the Ohio State Medical Association's state-wide plan for home-town treatment of veterans with service-connected disabilities became effective July 1.

A communication signed by Association President E. P. McNamee, Cleveland, has been mailed from the headquarters office to every member of the State Association, explaining the details of the plan and urging 100 per cent participation.

ASKED TO SIGN AND MAIL CARDS

With the letter was enclosed a mailing card, already addressed to State Association Headquarters in Columbus, making it necessary only for the physician member to sign the card and drop it into the mail.

Only those members who have returned these cards are on the original list of participants, **but others are urged to sign and return their cards immediately in order that their names may be added.**

This program is the result of many hours of hard work on the part of the State Association's Committee on Medical Care of Veterans, headed by Past-President Harry V. Paryzek of Cleveland, and was approved by Council on March 10.

PRIVATE PRACTICE CAN DO THE JOB

In offering the veteran an opportunity to use his family doctor or a specialist in his home town with the government paying the bills, the program recognizes the value of physician-patient relationship in the care of the veteran, and **gives the medical profession a chance to prove again that private practice can best handle the job, no matter how big it is.**

Full cooperation of all members of this Association in giving the disabled veterans satisfactory medical service will aid in the decentralization plans of the Veterans Administration and will minimize the expansion of present governmental hospital facilities and institutionalized medical care.

In that it offers care of the highest type to the men whose sacrifices make them deserving of the best of medical treatment, the program should be of real value to the veteran with service-connected disability.

PLAN OF OPERATION IS SIMPLE

The plan itself is exceedingly simple. When a member of the Association has mailed his card and it is received in Columbus, his name is placed on a list of fee-designated physicians and the branch office of the Veterans Administration in Columbus is notified that his services are available.

Lists are broken down by counties and districts, and when a veteran's request for medical treatment has been approved by the VA, he is asked to name his choice of physicians. If his first choice is not one of the participants in the program, it will be necessary for him to name other physicians whose services he might desire, until a participant is found. However, with 100 per cent cooperation on the part of the membership of the Association, it will not be necessary to disappoint any disabled veteran.

The physician chosen will receive a letter from the Veterans Administration advising him of the authorization for treatment and his selection by the veteran.

PAYMENT DIRECT TO PHYSICIAN

When the veteran applies directly to the fee-designated physician for treatment, the physician must submit VA medical form 2690 to obtain authority before payment can be guaranteed. This is necessary to assure that the ailment is service-connected, and thus eligible for treatment at the government's expense.

A physician who has rendered services in an authorized case should submit his fee bill to the office of the Veterans Administration which has authorized the treatment, and payment will be made direct to the doctor.

It is urged that the above program not be confused with a recent temporary listing of physicians willing to assist the Veterans Administration in making physical examinations of veterans seeking pensions, disability rating, and other services. This new program supercedes that one, and includes treatment as well as examinations.

All physicians should sign up for the new program regardless of whether his name is on the lists of examining physicians.

DETAILS OF PROGRAM

The following material includes a detailed description of the approved proposal, the designated fee schedule, summary of regulations applying to the Ohio agreement, and a sample form used in requesting authority for treatment:

TEXT OF AGREEMENT

Following is the text of the agreement between the Ohio State Medical Association and the Veterans Administration for the medical

care of veterans with service-connected disabilities which will become effective July 1, 1946:

1. It is the purpose of the Ohio State Medical Association to collaborate with the Veterans Administration in a manner which will provide the best possible medical care for veterans residing in the State of Ohio.

2. The Ohio State Medical Association will request all of its members to participate in a state-wide program whereby physicians in private practice will render medical services (examinations, treatments, and counsel) in such cases as may be authorized by the Veterans Administration.

3. The Ohio State Medical Association will submit to the Veterans Administration a list of members who desire to provide services for eligible veterans in home communities of such veterans.

4. The physicians so listed may be appointed as fee-designated physicians of the Veterans Administration.

5. Such list may be augmented from time to time as additional physicians indicate a desire to participate in the program.

6. By notice in writing, a physician may at any time request that his name shall be removed from the list of fee-designated physicians.

7. Fees for medical services in authorized cases shall be paid by the Veterans Administration to the physician rendering the service in accordance with the fee schedule which is attached hereto and made a part of this agreement. It is understood that unusually involved cases and services not scheduled will be subject to review by the Ohio State Medical Association and for recommendation to the Veterans Administration as to the appropriate fee.

8. The Ohio State Medical Association will assist the Veterans Administration in establishing for examinations and treatments a list of competent specialists who meet the qualifications for specialists of the Veterans Administration.

9. Lists submitted by the Ohio State Medical Association will be broken down by counties or districts in order that the veteran for whom services are authorized may select a physician practicing in his home community.

10. The Veterans Administration will handle administrative and clerical details in connection with the authorization of examinations or treatments and the maintenance of records; and will arrange for transportation of the veteran if necessary.

11. When authorizing examination or treatment, the Veterans Administration will furnish to the veteran proof of such authorization and a list of fee-designated physicians in the county or district in which the veteran is located in order that he may select his own physician for the services authorized.

12. The Veterans Administration will review reports of examinations and services to determine their adequacy. No fees will be paid by the Veterans Administration for reports which are not acceptable to the Veterans Administration nor for services rendered in unauthorized cases.

13. The Ohio State Medical Association will establish one or more boards of review composed of physicians. It shall be the duty of such board to review reports which are deemed by the Veterans Administration to be inadequate or which do not meet the requirements of the Veterans Administration; to recommend, at its discretion, the disqualification of any physician from further work with the Veterans Administration whose work is found by the board to be incomplete or unsatisfactory; to advise and assist the Veterans Administration on other matters within the scope of this program.

14. The Ohio State Medical Association does not propose to make any charge for any service rendered to the Veterans Administration under this agreement.

FEE SCHEDULE

Following is the Medical and Surgical Fee Schedule, agreed to by the Ohio State Medical Association and the Veterans Administration, in connection with the operation of the Ohio program for the medical care of veterans with service-connected disabilities by home-town physicians:

MISCELLANEOUS

1.	First treatment at office (day)	$ 3.00
2.	First treatment at home or hospital (day)	5.00
3.	First treatment (emergency, office, home, or hospital, 9:00 P. M. to 7:00 A. M.)	7.00
4.	Subsequent treatment at office, including ordinary medication and dressing	2.00
5.	Subsequent treatment at home, including ordinary medication and dressing	3.00
6.	Subsequent treatment at hospital	2.50
7.	Suturing lacerations (plus regular treatment fee)	3.00
8.	Injection (prophylactic) antitetanic serum (plus regular treatment fee)	2.00
9.	Injection (prophylactic) combined gas bacillus and tetanus antitoxin (plus regular treatment fee)	4.00
10.	Blood transfusion	35.00
11.	Amount allowed for blood furnished, when not donated, per 100 cc	5.00
12.	Colonic irrigation	3.00
13.	Non-surgical drainage of the gall bladder	10.00

14. Injection of alcohol, trigeminal nerve 25.00
15. Intravenous injection, including cost of drug
    First injection 4.50
    Each additional injection 3.50
16. Psychiatric treatment (psycho therapeutic conference), session of at least 50 minutes 10.00
16a. Psychiatric treatment (psycho therapeutic conference), session of 25 minutes or less 5.00
16b. Treatment of neurologist 5.00
(Treatment is understood to be the usual follow-up care and observation after diagnosis has been made at original neurological examination.)
16c. Intravenous sodium amytal procedure 10.00
16d. Electro-encephalography 20.00
16e. Electroshock treatment 10.00
17. Psychometric testing 8.00
18. Physiotherapy
    First treatment 3.00
    Each additional treatment 2.00
(Fees for physiotherapy not approved for more than ten treatments unless authorized.)
19. Application of plaster casts (including material) in cases not covered by flat fee
    Hand, wrist and forearm 10.00
    Arm, elbow and forearm 10.00
    Leg, ankle and foot 15.00
    Thigh, knee and leg 15.00
    Body cast (axillae to trochanters) 40.00
    Spica, single or double 40.00
    Shoulder spica, including arm, forearm, hand and body down to trochanters 40.00
    Head, neck and torso (Minerva Jacket) 40.00
20. Spinal medication, any type, as with meningococcus serum, salvarsan, etc., (exclusive of cost of drug or biological) 15.00
21. Surgical assistant's fee, except for unusual condition 10.00
22. Consultation—only by authority from central office, except in emergency 10.00
23. Mileage, outside corporation limits and in addition to regular fee 50 cents per mile one way

EXAMINATIONS

24. Bronchoscopy 50.00
25. Bronchoscopy and biopsy 50.00
26. Dermatological examination 5.00
27. Electrocardiogram with interpretation 10.00
28. Encephalography, air injection by spinal route for diagnostic purposes 40.00
29. Esophagoscopy 50.00
30. Examination of ears, nose and throat (separately or together) 5.00
31. Special ear examination, including audiometric test, with chart 15.00
32. Special ear examination to include either caloric or Barany test, or both, with report 15.00
33. Examination of eyes (to include either a copy of the prescription ordered or the retinoscopic correction of the refractive error, the fundus and field findings—the latter by chart in all cases of optic atrophy) 15.00
34. Examination of eyes with refraction, if mydriatic is used (to include either a copy of the prescription ordered or the retinoscopic correction of the refractive error, the fundus and field findings—the latter by chart in all cases of optic atrophy) 15.00
35. Combined examination of eyes, ears, nose and throat, with refraction (with or without mydriatic) 15.00
36. Gastroscopy 50.00
37. Genito-urinary examination without cystoscopy 5.00
38. Genito-urinary examination with cystoscopy 25.00
39. Genito-urinary examination with cystoscopy and ureteral catheterization 25.00
40. Gynecological examination 5.00
41. Complete examination of heart, including electrocardiography 15.00
42. Physical examination of heart or lungs, or both 5.00
43. Neurological examination (complete) 15.00
44. Psychiatric examination (complete) 15.00
45. Routine office physical examination 5.00
46. Orthopedic examination 5.00
47. Proctoscopy or sigmoidoscopy 5.00
48. General surgical examination 5.00
49. Thoracoscopy 50.00
50. Ventriculography, air injection through skull for diagnostic purposes 50.00
51. Allergic investigation, including complete examination, allergy study and report 40.00

CLINICAL LABORATORY EXAMINATIONS

BACTERIOLOGICAL EXAMINATIONS:

52. Cultural examination for fungi 5.00
53. Microscopic examination for fungi 1.00
54. Pneumococcus typing 5.00
55. Pus or exudate (smear) 1.00
56. Pus or exudate, cultural examination, including classification of organism 5.00
57. T. Pallidum (dark field) 5.00
58. Throat culture, including classification of organism 5.00
59. Throat smear 1.00

BLOOD:

60. Agglutination test for typhoid, paratyphoid, dysentery, or undulant fever 2.00
61. Bleeding time 1.00
62. Blood calcium 3.00
63. Blood chlorides 3.00
64. Blood culture, including classification of organism in positive culture 5.00

65. Blood platelet count 2.00
66. Blood smear for malaria 1.00
67. Blood typing (grouping including Rh) 2.00
68. Carbon dioxide combining power of blood plasma (Van Slyke) 3.00
69. Chemical examination of blood, complete, including creatinin, dextrose, urea nitrogen (or non-protein N) and uric acid 10.00
70. Cholesterol 3.00
71. Coagulation time 1.00
72. Complement fixation test for gonococcus infection 5.00
73. Complement fixation test for syphilis 5.00
74. Complement fixation test for tuberculosis 5.00
75. Creatinin 3.00
76. Dextrose 3.00
77. Total erythrocyte count 1.50
78. Fragility test for erythrocytes 3.00
79. Hemoglobin estimation 1.00
80. Hydrogen ion concentration 3.00
81. Differential leucocyte count 1.50
82. Total leucocyte count 1.50
83. Complete blood count, including total erythrocyte count, hemoglobin estimation, differential leucocyte count and total leucocyte count 5.00
84. Non-protein nitrogen 3.00
85. Occult blood 1.00
86. Blood phosphorous 3.00
87. Precipitation test for syphilis 2.00
88. Reticulocyte count 2.00
89. Sedimentation rate 2.00
90. Estimation of sugar tolerance 5.00
91. Urea nitrogen 3.00
92. Uric acid 3.00
93. Van den Bergh blood test for icterus 2.00
94. Volume index 2.00

FECES:

95. Cultural examination of feces for causative micro-organism (including classification of bacterium) 5.00
96. Fat in feces 1.00
97. Parasites and ova 2.00

PATHOLOGICAL EXAMINATIONS:

98. Autopsy, complete, with report (including histological examinations) 125.00
99. Tissue examination, with report 5.00

SPINAL FLUID:

100. Examination of spinal fluid for causative organism (smear) 2.00
101. Cell count 1.50
102. Colloidal gold reaction 3.00
103. Complement fixation test for syphilis 5.00
104. Cultural examination of spinal fluid, including classification of causative micro-organism 5.00
105. Globulin test 1.00
106. Complete examination of spinal fluid, including complement fixation test, colloidal gold reaction, globulin test, and cell count 5.00
107. Precipitation test for syphilis 2.00
108. Tubercle bacillus (plain smear) 2.00
109. Tubercle bacillus (concentration method) 3.00

STOMACH CONTENTS:

110. Examination of duodenal content for pancreatic ferments 3.00
111. Examination of gastric content for acidity, by histamine 3.00
112. Examination of gastric content for pepsin 3.00
113. Routine, chemical (including test meal and withdrawal of stomach content) 5.00

URINE:

114. Chemical examination, routine 1.00
115. Chemical and microscopical examination 1.00
116. Chlorides 3.00
117. Creatinin 3.00
118. Cultural examination, including classification of micro-organism 5.00
119. Hydrogen ion concentration 1.00
120. Mosenthal test 3.00
121. Total nitrogen 3.00
122. Renal function test, (including phenolsulfonphthalein) 3.00
123. Tubercle bacilli 2.00
124. Urea nitrogen 3.00
125. Uric acid 3.00
126. Urobilin 1.00

MISCELLANEOUS EXAMINATIONS:

127. Animal inoculation for diagnosis, with report of autopsy 10.00
128. Preparation of autogenous vaccine 5.00
129. Determination of basal metabolic rate 5.00

SURGICAL PROCEDURES

The flat fee includes after-care, and unless otherwise specified, covers a period of sixty days. It is exclusive of hospital charges, anesthetic and X-ray fees.

130. Abdominal fixation for prolapse of rectum 150.00
131. Adenectomy, cervical, inguinal, etc. (minor) 20.00
132. Adenectomy, cervical, inguinal, etc. (radical) 100.00
133. Anal fissure, operation for 40.00
134. Anastomosis, intestinal 150.00
135. Anastomosis, uretero-intestinal 150.00
136. Ankle joint, excision of 100.00
137. Apicolysis 100.00
138. Appendectomy 100.00
139. Arthroplasty, major joint 150.00
140. Biopsy 10.00
141. Bone graft (long bones) 150.00
142. Bone plate, removal of 50.00
143. Breast, resection of (simple) 100.00
144. Breast, resection of (radical) 150.00
145. Carcinoma of lower lip, excision of 50.00
146. Carcinoma of rectum, excision of 200.00
147. Carcinoma of tongue, excision of 100.00

148. Cardiospasm, dilation for 50.00
149. Cartilage of condyle of femur, removal of 100.00
150. Semilunar cartilage, removal from joint 100.00
151. Cervix, amputation of 75.00
152. Cholecystectomy 150.00
153. Cholecystotomy 150.00
154. Choledochotomy 150.00
155. Chordotomy 150.00
156. Circumcision 25.00
157. Claw foot, operation for 75.00
158. Coccyx, excision of 50.00
159. Colostomy 150.00
160. Colporrhaphy 75.00
161. Cystotomy, suprapubic 75.00
162. Dupuytren's contraction, operation for 125.00
163. Elbow joint, excision of 100.00
164. Epididymectomy 75.00
165. Esophagus, dilation of by means of Bougies or sounds 50.00
166. Femoral artery, ligation of 75.00
167. Fecal fistula, abdominal, operation for 150.00
168. Fistula, rectovaginal, operation for 150.00
169. Fistula, urethral, operation for 100.00
170. Fistula, vesicovaginal, operation for 150.00
171. Fistula-in-ano, operation for 50.00
172. Fulguration of tumor of bladder, trachea, or esophagus (minor) 50.00
173. Fulguration of tumor, superficial 10.00
174. Gasserian ganglion, excision of 150.00
175. Gastrectomy (partial) 150.00
176. Gastro-enterostomy 150.00
177. Hallux valgus, operation for 50.00
178. Hallux valgus, bilateral, operation for 75.00
179. Hammer toe, operation for 25.00
180. Heart, operation on 150.00
181. Hemorrhoidectomy 50.00
182. Herniotomy, diaphragmatic 150.00
183. Herniotomy, ventral, inguinal, or femoral 100.00
184. Herniotomy, ventral, inguinal, or femoral (bilateral) 150.00
185. Hip joint, excision of 150.00
186. Hydrocele, aspiration of 5.00
187. Hydrocele, operation for 50.00
188. Hysterectomy, abdominal or vaginal (including removal of adnexa, if indicated) 150.00
189. Ingrown toenail, excision of 15.00
190. Intestinal obstruction, operation for 150.00
191. Knee joint, excision of 100.00
192. Laminectomy 150.00
193. Laparotomy, exploratory 100.00
194. Laparotomy and drainage, general peritonitis 125.00
195. Litholapaxy 75.00
196. Lobectomy 150.00
197. Meckel's diverticulum, excision of 100.00
198. Nephrectomy or Nephrotomy 150.00
199. Nephropexy 125.00
200. Nerve, suture of 100.00
201. Supra-orbital nerve, injection of 10.00
202. Neuroma, resection of 75.00
203. Oleothrax 50.00
204. Orchidectomy 50.00
205. Osteomyelitis, operation for
Small bones 50.00
Large bones (tibia,) fibula, femur, humerus, radius, ulna, skull, spine, pelvis) 100.00
206. Ovariotomy 100.00
207. Papilloma of bladder, operation for 75.00
208. Paracentesis of abdomen 15.00
209. Paracentesis of pericardium 25.00
210. Paracentesis of thorax 10.00
211. Perineum, repair of 75.00
212. Phrenic nerve operation 50.00
213. Pneumolysis, extrapleural or intrapleural 100.00
214. Pneumonectomy 200.00
215. Pneumonotomy, cautery 100.00
216. Pneumoperitoneum, first induction 25.00
217. Pneumoperitoneum, refills 10.00
218. Artificial pneumothorax, first induction 25.00
219. Artificial pneumothorax, refills 10.00
220. Prostatectomy, perineal 150.00
221. Prostatectomy, suprapubic (one or two stages) 150.00
222. Prostatic resection, transurethral 150.00
223. Cisterna puncture, includng local anesthetic and obtaining fluid 50.00
224. Lumbar puncture, including local anesthetic and obtaining fluid 10.00
225. Pyclotomy, with removal of calculus 150.00
226. Pyloroplasty 150.00
227. Salpingectomy 100.00
228. Scaleniotomy 50.00
229. Sequestrum, removal of (deep) 150.00
230. Sequestrum, removal of (superficial) 50.00
231. Shoulder joint, excision of 100.00
232. Skull, decompression of 100.00
233. Fixation of spine, operation for (Albee or Hibbs') 150.00
234. Splenectomy 150.00
235. Stricture of rectum, operation for 50.00
236. Sympathectomy, cervical 175.00
237. Sympathectomy, periarterial 100.00
238. Tenorrhaphy, one 30.00
239. Tenorrhaphy, each additional 15.00
240. Tenotomy 35.00
241. Thoroctomy 100.00
242. Thoracoplasty, each stage 100.00
243. Thyroid artery, ligation of 75.00
244. Thyroidectomy 150.00
245. Torticollis, operation for 75.00
246. Tumor, abdominal, removal of 125.00
247. Tumor of brain, operation for 200.00
248. Tumor, gastro-intestinal tract, resection of, including intestinal anastomosis 150.00
249. Tumor or cyst, deep, removal of 25.00
250. Tumor or cyst, superficial, removal of 10.00

251.	Ulcer, gastric or duodenal, operation for	150.00
252.	Ureteral stone, removal of	125.00
253.	Urethral stricture, dilatation of	5.00
254.	Urethrotomy, external	75.00
255.	Urethrotomy, internal	50.00
256.	Prolapsus uteri, operation for, including perineal repair	150.00
257.	Uterine displacement abdominal, operation for	150.00
258.	Uterus, dilatation and curretage of	50.00
259.	Varicocele, operation for	50.00
260.	Varicose veins, injection treatment, each injection	5.00
261.	Varicose veins, one leg, operation for	60.00
262.	Varicose veins, both legs, operation for	100.00
263.	Venesection	15.00
264.	Whitehead's operation	75.00
265.	Wrist joint, excision of	75.00

AMPUTATIONS

The flat fee includes amputation and sixty days' after-care. It is exclusive of hospital charges, anesthetic and X-ray fees.

In cases of more than one amputation, the fee shall be the major one, and an additional fifty per cent of each of the others.

266.	Thigh at hip joint (disarticulation)	150.00
267.	Thigh at knee joint or above	125.00
268.	Leg below knee to ankle joint, inclusive	100.00
269.	Through foot	75.00
270.	Arm at shoulder joint	125.00
271.	Hand at wrist joint and forearm or arm	100.00
272.	Finger	30.00
273.	Toe	30.00

ANESTHESIA

Inhalation, intravenous, spinal, and rectal:

274.	First thirty minutes or fraction thereof	10.00
275.	Each succeeding thirty minutes or fraction thereof, additional	5.00
276.	Local anesthesia used in reduction of fracture or dislocation	5.00

No additional fee is approved for local anesthesia used in connection with usual treatments at office, home, or hospital.

DISLOCATIONS

The flat fee includes reduction and sixty days' after-care. It is exclusive of hospital charges, anesthetic and X-ray fees.

In a case of more than one dislocation, the fee shall be the major one, and an additional fifty per cent of the fee prescribed for each of the others herein classified.

In cases involving fractures also, the fee shall be the major one, and an additional fifty per cent for each of the others.

Casts applied during the period covered by the flat fee are considered as part of the treatment and no extra fees for application are approved.

277.	Shoulder	35.00
278.	Clavicle	50.00
279.	Elbow	50.00
280.	Hip	75.00
281.	Knee	75.00
282.	Patella	10.00
283.	Ankle	40.00
284.	Finger	10.00
285.	Toe	10.00
286.	Lower jaw	10.00
287.	Carpal bones	50.00
288.	Vertebra	150.00

FRACTURES

The flat fee includes reduction and casts and sixty days' after-care. It is exclusive of hospital charges, anesthetic and X-ray fees.

In a case where more than one bone is fractured, the fee shall be the major one, and an additional fifty per cent of the fee prescribed for each of the others.

In cases involving dislocation also, the fee shall be the major one, and an additional fifty per cent for each of the others.

Casts applied during the period covered by the flat fee are considered part of the treatment and no extra fees for application are approved.

Compound fractures—An additional charge of fifty per cent is approved in compound fractures.

Open operations—An additional charge of fifty per cent, except where specified in the fee schedule, is approved when it is necessary to perform an open operation for reduction and fixation. This is not in addition to the amount allowed for compound fractures.

289.	Humerus	100.00
290.	One bone of forearm	50.00
291.	Both bones of forearm	100.00
292.	Colles fracture (including fractured tip of styloid and dislocation of head of ulna)	50.00
293.	Head or neck of radius	60.00
293.	Carpal bones	25.00
294.	Femur	125.00
295.	Tibia	75.00
296.	Fibula	35.00
297.	Tibia and fibula	100.00
298.	Patella (operative)	100.00
299.	Patella (non-operative)	50.00
300.	Os Calcis (operative)	100.00
301.	Os Calcis (non-operative)	50.00
302.	Malar bone	25.00
303.	Sacrum	75.00
304.	Sternum	75.00
305.	Astragalus (operative)	100.00

306. Astragalus (non-operative) 50.00
307. Tarsal, other than os calcis or astragalus 25.00
308. Phalanx 20.00
309. Metatarsal or metacarpal 25.00
310. Rib, single (uncomplicated) 10.00
311. Nasal bones:
Requiring manual adjustment only 10.00
Requiring intranasal manipulation and packing 25.00
312. Pelvis 75.00
313. Coccyx:
Without operation (exclusive of after-care) 10.00
Surgical removal, including after-care 50.00
314. Lower jaw, non-operative (not including dental work) 40.00
315. Upper jaw, non-operative (not including dental work) 25.00
316. Clavicle 50.00
317. Scapula 50.00
318. Skull, operative 100.00
319. Vertebra 150.00

INCISION AND DRAINAGE OF ABSCESS

The flat fee includes fifteen days' after-care unless otherwise indicated and is exclusive of hospital charges, anesthetic and X-ray fees.

320. Brain abscess 150.00
321. Carbuncle, excision of 25.00
322. Cellulitis, incision and drainage 25.00
323. Deep abscess (including ischiorectal). Fee does not include usual 15 days' after-care. Additional charge may be allowed for after-care 20.00
324. Empyema, incision and drainage, including rib resection 100.00
325. Liver abscess 150.00
326. Oral abscess (not to include dental or peridental) 15.00
327. Prostatic abscess, incision and drainage 50.00
328. Superficial abscess. Fee does not include usual 15 days' after-care. Additional charge may be allowed for after-care 5.00
329. Subphrenic abscess 150.00

OPHTHALMOLOGICAL PROCEDURES

The flat fee includes after-care and, unless otherwise indicated, covers a period of sixty days. It is exclusive of hospital charges, anesthetic and X-ray fees.

330. Cataract, needling operation for 50.00
331. Cataract, operation for 150.00
332. Chalazion, operation for 10.00
333. Corneal ulcer, cauterization of (chemical) 5.00
334. Corneal ulcer, cauterization of (thermal) 10.00
335. Extensive peripheral corneal ulcer, cauterization of 25.00
336. Ectropion, operation for 50.00
337. Entropion, operation for 50.00
338. Enucleation of eye:
Simple operation 75.00
Implantation operation 100.00
339. Removal of foreign body:
Simple. Regular fee for first treatment of injury.
Embedded, difficult, complicated, or multiple 5.00-15.00
Removal of eyeball (deep) exclusive of after-care 75.00-100.00
340. Grattage of lids for trachoma 10.00
341. Hordeolum, operation for 5.00
342. Iridectomy 75.00
343. Lacrymal duct, dilatation of 10.00
344. Lacrymal sac, excision of 50.00
345. Pterygium, operation for 25.00
346. Ptosis, skin and tarsal resection, operation for 100.00
347. Strabismus, operation for 100.00

EAR, NOSE AND THROAT SURGICAL PROCEDURES

Procedures covered by flat fee shall include after-care for a period of three weeks, unless otherwise indicated. It is exclusive of hospital charges, anesthetic and X-ray fees.

348. Mastoid, acute, operation for 100.00
349. Mastoid, radical, operation for 125.00
350. Ossiculectomy 100.00
351. Paracentesis 10.00
352. Polypus, removal of 25.00
353. Lateral sinus, drainage of 150.00
354. Adenoidectomy 20.00
355. Antrum, intranasal, drainage of 20.00
356. Antrum, radical, operation for 100.00
357. Cleft palate, operation for 150.00
358. Harelip, operation for 75.00
359. Intubation 25.00
360. Laryngectomy 150.00
361. Larynx, cauterization of 25.00
362. Tumor of larynx, removal of 100.00
363. Nasal polypus, removal of 25.00
364. Nasal septum, submucous resection of 75.00
365. Pharyngeal abscess, operation for 25.00
366. Accessory nasal sinuses, irrigation of 10.00
367. Ethmoid sinus, radical, operation for 75.00
368. Frontal sinus, intranasal, drainage of 50.00
369. Frontal sinus, radical, operation for 100.00
370. Sphenoid sinus, drainage of 50.00
371. Tonsillar abscess, operation for 15.00
372. Tonsillectomy 40.00
373. Tonsillectomy and adenoidectomy 50.00
374. Tracheotomy 50.00
375. Turbinate bone, galvano-cauterization of 20.00
376. Turbinectomy 25.00

X-RAY INTERPRETATION, X-RAY THERAPY AND RADIUM THERAPY

Both anteroposterior and lateral views are to be submitted for all parts of the body, with the exception of the shoulder and hip joints, pelvis

and lungs, in which examinations the anteroposterior view only is required. Not less than three views in different directions are to be submitted in examination of the skull.

Cervical, dorsal, lumbar and sacrococcygeal areas of the spine will be considered as separate parts. The entire pelvis and upper thirds of the femora (if they are included on the film) are considered as one part. The entire chest is considered as one part.

Stereoscopic examination may be made when indicated. The fee for such examination is the established fee, plus fifty per cent additional.

377.	Examination of any part of body exclusive of fingers and toes	10.00
378.	Examination of fingers or toes	5.00
379.	Examination of skull, three views	15.00
	(Where examination is made of more than one part of the body, the fee shall be the major fee, plus fifty per cent of the established fee for other parts.)	
380.	Subsequent or recheck examination	Fifty per cent of established fee.
381.	Accurate localization of foreign body in the eye (complete)	25.00
382.	Fluoroscopy for removal of foreign body	5.00
383.	Examination of colon by barium enema	20.00
384.	Complete examination of gastro-intestinal tract by barium meal	25.00
385.	Pyelography, retrograde	25.00
386.	Complete examination of gastro-intestinal tract by barium meal and barium enema	35.00
387.	Intravenous pyelogram, including cost of dye	20.00
388.	Encephalogram	20.00
389.	Dental:	
	Single film	2.00
	Complete series	15.00
390.	X-ray Therapy:	
	Superficial X-ray therapy	5.00
	Deep X-ray therapy	10.00
391.	Radium therapy, per milligram hour	0.05

STANDARDS FOR NEUROPSCHIATRISTS TO BE DESIGNATED FOR THERAPY

Psychiatrists:

Qualifications:

a. Certified in Psychiatry by American Board of Psychiatry and Neurology, or

b. Possession of one of following ranks in an accredited Medical School.
   1. Any professorial rank in Psychiatry.
   2. Associate in Psychiatry.

c. Experience:
   1. At least four years of two half days a week in an accredited Mental Hygiene Clinic or similar institution in which modern therapeutic principles and techniques were practiced, or
   2. Certification by the American Psychoanalytical Association and four years' practice of Psychiatry using this, or other, forms of modern psychiatric treatment, or
   3. Two years' certified training and experience in the Armed Forces or in any other accredited institution in which intensive individual therapy was practiced and taught, with two additional years of similar practice, either private or institutional.

Neurologists:

Qualifications:

a. Certification in Neurology by American Board of Psychiatry and Neurology.

IMPORTANT REGULATIONS

Following are some of the more important rules and regulations of the Veterans Administration which will govern the administration of the medical care program for veterans with service-connected disabilities, worked out between the Ohio State Medical Association and the Veterans Administration:

ELIGIBILITY

Only veterans with service-connected disabilities are eligible to receive medical service at the expense of the Veterans Administration.

Only physicians whose names are on the list of fee-designated physicians of the Veterans Administration will be eligible for reimbursement by the Veterans Administration for services rendered an eligible veteran, except in emergencies. **(See paragraph "Emergency Treatment".)**

AUTHORIZATION

Veterans Who Apply Directly To A Physician for Treatment: When a veteran applies directly to a fee-designated physician for treatment, the physician must submit the request for authority to treat the veteran to the nearest Veterans Administration office. The Veterans Administration must approve this request before payment of the physician can be guaranteed by the Veterans Administration. **(See list of Veterans Administration Ohio offices on page 756.)**

The request for authority for treatment should be submitted on Medical Form 2690. **(Copy of form on page 755.)** A supply of this form will be furnished all fee-designated physicians.

Immediately upon receipt of a request for authority for treatment, the Veterans Administration office receiving the request will advise the physician as to whether or not treatment is authorized and any other information that may be deemed helpful to the physician.

If the physician will bear in mind that approval is mandatory before the Veterans Administration can be expected to assume payment and that arrangements for payment should be made with the veteran direct in the event treat-

(Continued on page 757)

VETERANS ADMINISTRATION
Medical Form 2690
Rev. July 1938

(COPY)

REQUEST FOR AUTHORITY FOR TREATMENT

_____ _____
(Place) (Date)

TO CHIEF MEDICAL OFFICER,

_____ _____
(Name of beneficiary) (C-No.)

_____
(Location of office)

_____
(Address of beneficiary)

I. REQUEST TO BEGIN TREATMENT

1. The above named applied to me _____ (Date) requesting out-patient treatment.
2. *This applicant has never before been treated by me. He exhibited _____ (Certificate of discharge; other papers) indicating that he was enlisted _____ (Date) and was discharged _____ (Honorably; not dishonorably; for disability) on _____ (Date) and that his organization was _____ (Specify) and rank _____ (Specify)

   *This applicant last received authorized treatment from me on or about _____ (Date)
3. His complaints were _____

   My clinical findings were _____

   _____

   My present diagnosis is _____
4. His condition* (was) (was not) medically emergent. He is *(able) (not able) to report at my office. Hospitalization *(is) (is not) indicated at present.
5. *I rendered no treatment. *I rendered emergency treatment, as follows:

   _____
6. *I recommend _____ (Number) treatments. *I request authorization to cover my emergency treatment, and _____ (Number) additional treatments.

_____ M. D.
(Signature of physician)

*Delete inapplicable words.

(COPY)

II. REQUEST TO CONTINUE TREATMENT

Your authorization for treatment of the *(beneficiary) (beneficiaries) named below *(expires) (expired)_____. I recommend the following additional treatments:

(Date)

NAMES	C-No.	VISITS		NAMES	C-No.	VISITS	
		H.	O.			H.	O.

_____M. D.

*Delete inapplicable words.

(Signature of physician)

INSTRUCTIONS

This form will be used by both part-time and fee-basis physicians in requesting authority either (I) to begin treatment, in emergency or nonemergency applications for treatment; and (II) to continue treatment of a beneficiary or beneficiaries.

Care must be taken to complete only such part of the form as is appropriate in the circumstances, and to delete inapplicable words.

Under column "Visits," enter the number of Home Visits under H, and Office Visits under O.

In requesting authority (I) to begin treatment, the executed form will be submitted whenever the applicant contacts the physician. In emergency cases, when treatment was rendered, the form must be submitted within 24 hours of such emergency treatment, so that it can be covered by authority.

In requesting authority (II) to continue treatment, the form will be submitted on the 23rd of the month, so that the chief medical officer can prepare and issue his authorization (on Form 2639) for treatments to be rendered in the succeeding month.

Offices of the Veterans Administration in Ohio Which Will Handle Details of Medical Care Program

Following are the regional and sub-regional offices of the Veterans Administration in Ohio through which administrative details of the medical care program for veterans with service-connected disabilities will be handled, under the general supervision of Ralph H. Stone, deputy administrator, and Dr. Neville H. McNerney, medical director, Branch Office, No. 6, Columbus, with jurisdiction over Veterans Administration activities in Ohio, Michigan and Kentucky.

CINCINNATI—Regional Office—Brown, Butler, Clermont, Clinton, Hamilton, Highland and Warren.

COLUMBUS — Sub-Regional — Delaware, Fairfield, Fayette, Franklin, Hocking, Licking, Logan, Madison, Muskingum, Perry, Pickaway and Union.

DAYTON — Sub-Regional — Champaign, Clark, Darke, Greene, Miami, Montgomery, Preble and Shelby.

MARIETTA — Sub-Regional—Athens, Guernsey, Meigs, Monroe, Morgan, Noble and Washington.

PORTSMOUTH—Sub-Regional—Adams, Gallia, Jackson, Lawrence, Pike, Ross, Scioto and Vinton.

CLEVELAND—Regional—Ashtabula, Cuyahoga, Geauga, Lake and Lorain.

AKRON—Sub-Regional—Medina, Portage, Stark, Summit and Wayne.

LIMA—Sub-Regional—Allen, Auglaize, Hancock, Hardin, Mercer, Paulding, Putnam, Seneca, Van Wert and Wyandot.

MANSFIELD — Sub-Regional — Ashland, Erie, Coshocton, Crawford, Holmes, Huron, Knox, Marion, Morrow and Richland.

STEUBENVILLE — Sub-Regional — Belmont, Carroll, Columbiana, Harrison, Jefferson, Tuscarawas.

TOLEDO — Sub-Regional — Defiance, Fulton, Henry, Lucas, Ottawa, Sandusky, Williams, Wood.

ment is not approved, a better understanding will be accomplished.

Veterans Who Apply Direct to Veterans Administration for Treatment by Private Physician: A veteran who applies directly to the Veterans Administration for treatment for a service-connected condition will be given a letter advising him that he is authorized to consult a fee-designated physician. A letter will be sent to the physician selected by the veteran advising him of the authorization.

SUBMISSION OF FEE BILLS

A physician who has rendered services in an authorized case should submit his fee bill for services rendered to the office of the Veterans Administration which authorized the treatment. Payment will be made direct to the physician by the Veterans Administration.

EMERGENCY TREATMENT

When a veteran requires emergency treatment, he should be treated immediately by the physician selected or called.

If the physician wishes to ascertain whether or not the Veterans Adminstraton will assume responsibility, a "collect" telephone call should be made by the physician to the Veterans Administration office in the area nearest the physician's office. At that time the physician will be advised as to what procedure to follow.

WHAT OUT-PATIENT SERVICE INCLUDES

This program for out-patient care of eligible veterans includes: Examinations and treatments in the physician's office, in the veteran's home, and in a private hospital which has contracted with the Veterans Administration to provide hospital services for veterans with service-connected disabilities.

At the discretion of the Veterans Admnistration, veterans with certain types of disabilities may be requested to report to a Veterans Administration hospital for treatment.

Memorial Library Honors Dr. Maxwell

A new medical library at General Hospital in Mansfield has been designated as the Frank H. Maxwell Memorial Library, in honor of Dr. Frank H. Maxwell, only Richland County physician to lose his life in World War II, according to the *Mansfield News Journal*

The library is the result of a gift of $15,000 from the medical staff in connection with the recently completed wing addition to the building.

A captain in the U. S. Army Medical Corps, Dr. Maxwell was killed on Mindoro Island, March 7, 1945.

New Law Aids V. A. in Securing Medical Department Personnel

The Veterans Administration in Ohio, Michigan, and Kentucky gained approximately 250 personnel in its medical department between January 3 and May 11 under new legislation which created a Department of Medicine and Surgery, according to Dr. Neville McNerney, Medical Director of the Columbus Branch Office for the three states.

The new medical department was authorized by Congress to enable the Veterans Administration to recruit physicians, dentists, and nurses required to care for veterans. The law removed physicians, dentists, and nurses from Civil Service regulations and offered them more attractive employment opportunities.

A personnel report as of May 11 showed 148 physicians, 20 dentists, and 537 nurses assigned full-time to Veterans Administration Hospitals and Domiciliary Homes in the three states. Increases included 40 physicians, 10 dentists, and 200 nurses.

There still is a need for additional physicians and approximately 375 nurses, Dr. McNerney said. The dental recruitment program has progressed so well during the past four months that the immediate need for dentists in Veterans Administration hospitals, clinics and other offices has been met.

The recruitment figure for medical personnel does not include those working for the Veterans Administration on a part-time, or fee basis.

Need Laboratory Specialists

Several new positions for professional laboratory personnel have been established in Veterans Administration hospitals in Ohio, Michigan, and Kentucky to keep abreast of the increasing variety and complexity of laboratory work and to introduce new clinical techniques, it has been announced at the Columbus Branch Office for the three states.

The new positions include biochemists, bacteriologists, and serologists or specialists in the study of serums.

The current program applies to Veterans Administration hospitals having more than 500 patients. Hospitals within this category in the three-state area are located at Chillicothe, Dayton, and Cleveland (Crile) in Ohio; Ft. Custer in Michigan; and Lexington and Louisville in Kentucky. A study is being made of the smaller hospitals to determine the extent and need for additional clinical technicians.

Applicants for any of the new positions should apply at the Branch Office, 52 S. Starling Street, Columbus.

Proceedings of The Council

Questions Pertaining to Ohio Medical Indemnity, Inc., and Taft Proposal Among Important Matters Considered at Meeting on June 9

A SPECIAL meeting of The Council of the Ohio State Medical Association was held in the State Headquarters Office, Columbus, on Sunday, June 9, 1946. Those attending the meeting were: President McNamee, President-Elect Rutledge, Past-President Schriver, Treasurer Worstell; Councilors Messenger, Bowman, Brindley, Dixon, Davis, Lincke, Tronstein, Micklethwaite, Clodfelter, and Knoble. In addition to members of The Council, the following also were present: Dr. B. J. Hein, Toledo, chairman of the Committee on Public Relations, and an A.M.A. delegate; Dr. D. J. Slosser, Defiance, alternate-delegate to the A.M.A.; Dr. C. C. Sherburne, Columbus, delegate to the A.M.A.; Dr. Jonathan Forman, Columbus, Editor of *The Journal*; Dr. H. M. Platter, Columbus, Secretary of the State Medical Board; Mr. Charles H. Coghlan, Columbus, Executive Vice-president of Ohio Medical Indemnity, Inc.; Mr. Wayne E. Stichter, Toledo, General Counsel, Ohio Medical Indemnity, Inc.; Dr. Carll S. Mundy, Toledo, Chairman of the Executive Committee, Ohio Medical Indemnity, Inc.; Executive Secretary Nelson; Assistant Executive Secretary Saville; and Mr. Page, News Editor of *The Journal*.

REPORT ON OHIO MEDICAL INDEMNITY

The first business considered was a report from Dr. Mundy, chairman of the Executive Committee of Ohio Medical Indemnity, Inc. Dr. Mundy informed The Council that the Executive Committee of Ohio Medical Indemnity, Inc., feels that it is highly desirable and important for the company to expand its activities into other areas of the state as rapidly as possible. He pointed out that the Toledo and Columbus Blue Cross Plans are very anxious to negotiate contracts with Ohio Medical within the next several weeks so that solicitation can be started in connection with re-enrollment of Blue Cross subscribers in those areas. Dr. Mundy stated that such expansion would require additional paid-in surplus due to the fact that the expansion would be undertaken earlier than originally planned.

Mr. Stichter pointed out that the most practical way of providing funds for the financing of the expansion program would be for the Ohio State Medical Association to purchase an additional amount of common shares, if action is taken by the stockholders of Ohio Medical Indemnity, Inc., authorizing the issuance of an additional number of common shares.

PURCHASE OF MORE STOCK AUTHORIZED

Following a general discussion, on **motion** by Dr. Knoble, seconded by Dr. Messenger, and **carried**, The Council authorized the purchase by the Ohio State Medical Association of up to 3,000 shares of common stock of Ohio Medical Indemnity, Inc., $1.00 par value at $7.00 per share in order to create an additional paid-in surplus for the expansion of the activities of the company.

STATEMENT ON TAFT BILL ADOPTED

There was an extended discussion of Senate Bill 2143, now pending before the United States Senate Committee on Education and Labor, and which was introduced on May 3, 1946, by Senator Robert A. Taft for himself and for Senator Smith of New Jersey and Senator Ball of Minnesota. Correspondence from Senator Taft and correspondence from individual members of The Council who had studied copies of the bill was read and discussed.

After thorough consideration of all the various important angles involved in the Taft proposal, The Council on **motion** by Dr. Brindley, seconded by Dr. Bowman, and **carried**, adopted an official statement regarding S. 2143.

(See page 760, this issue of *The Journal* for the text of the statement.)

PROCEDURE OUTLINED

On **motion** by Dr. Clodfelter, seconded by Dr. Dixon, and **carried**, The Council authorized the following in connection with the action taken above:

1. That a copy of the official statement be transmitted to Senator Taft with a covering communication, offering Senator Taft the assistance of a committee of the Ohio State Medical Association in working out clarifying modifications of technical details of the proposal and advising Senator Taft of other actions taken by The Council as set forth herein.

2. That the Ohio delegates to the American Medical Association be furnished with a copy of the action of The Council and officially instructed to present a resolution to the House of Delegates of the American Medical Association at the 1946 session of the A.M.A. in San Francisco, July 1-5, based on the official action of The Council.

3. That Senator Taft be provided with a copy of the resolution to be introduced by the Ohio delegates at the A.M.A. session and that he be informed of the action of the House of Delegates of the A.M.A. on such resolution.

4. That copies of the official statement of The Council and copies of the resolution which will be introduced by the Ohio delegates be forwarded

in advance of the A.M.A. meeting to the officials of the A.M.A.

1947 ANNUAL MEETING, MAY 6, 7, 8

The Executive Secretary reported on a survey which he and Mr. Saville, Assistant Executive Secretary, had made recently of annual meeting facilities in Cleveland. He recommended that an agreement be made with the Cleveland Public Auditorium for space for the scientific sessions, exhibits, and registration for the 1947 Annual Meeting; that the meeting be held on Tuesday, Wednesday, and Thursday, May 6, 7, and 8; and that Hotel Cleveland be designated as the headquarters' hotel and the place for holding the business sessions of the House of Delegates.

On **motion** by Dr. Knoble, seconded by Dr. Dixon, and **carried**, The Council approved and adopted the foregoing recommendations.

ADVERTISING PRINCIPLES APPROVED

A revised set of operative principles, governing the standards and policies of the Cooperative Medical Advertising Bureau of the American Medical Association, formulated by the Advisory Committee of the Bureau and subsequently approved by the Board of Trustees of the American Medical Association, were read and discussed. A request from the Bureau, that action be taken on these principles by the official agency of each state society in charge of publication activities, was considered. On **motion** by Dr. Brindley, seconded by Dr. Davis, and **carried**, the principles were officially approved.

MISCELLANEOUS BUSINESS

A question referring to legislation involving changes in the Medical Practice Act was discussed and referred to a committee for consideration.

The Executive Secretary reported on the status of the Ohio State Medical Association medical care program for veterans and pointed out that a communication would be sent to each member of the Ohio State Medical Association within a few days, giving him complete details of the program and asking each member to sign a card signifying his intention to participate, and that the program would go into effect officially on July 1, 1946.

On **motion** by Dr. Micklethwaite, seconded by Dr. Lincke, and **carried**, prorating of annual dues for new members for the third and fourth quarters of the year was authorized on the basis of $5.00 per capita for the third quarter and $3.00 per capita for the fourth quarter.

President McNamee advised The Council that the Ohio Division of the American Cancer Society desires to work out a program jointly with the Ohio State Medical Association for the holding of postgraduate courses or meetings on cancer, primarily for the general practitioners, and had certain funds which could be used for such a program.

On **motion** by Dr. Micklethwaite, seconded by Dr. Worstell, and **carried**, this was referred to the Committee on Education for a conference with officials of the cancer organization.

There being no further business, The Council adjourned to meet at the call of the President.

Attest: CHARLES S. NELSON,
Executive Secretary.

Hearings on Wagner Bill Resumed; Pepper Bill Also Scheduled

The Senate Committee on Education and Labor resumed hearings on S. 1606, the Wagner-Murray-Dingell bill, May 22, following a recess of two weeks.

Representatives of chiropractic organizations urged clarification of the bill for the purpose of recognizing chiropractic practitioners. Arthur J. Todd, manager of the Washington office of the Christian Science Committee on Publication, spoke in opposition to the measure, protesting that it would be highly unjust to require those who, because of their convictions, accepted remedies other than those provided by the bill, to obligate them to pay for the care that they could not use; thus, in fact, doubly taxing them.

In subsequent hearings, arguments against the bill were presented by representatives of a number of state and local medical societies, and by Dr. Joseph Wall, chairman of the Committee on Legislation of the American Academy of Pediatrics.

After another recess, hearings were postponed until June 18, to be continued through June 26. They will be resumed July 9, with probable completion by mid-July.

S. 1318, the Pepper bill, which, in effect, would extend the benefits of the Emergency Maternity and Infant Care Program for the wives and children of enlisted men, to all women and children in the country, was scheduled for a hearing by the Senate Committee on Education and Labor, on June 22. Ohio members of the Congress have been advised of the resolution recently adopted by the House of Delegates of the Ohio State Medical Association urging the discontinuance of the E.M.I.C. program and the defeat of the Pepper bill.

Request for Publications

The Scientific Library of the Bureau of Science, Manila, P. I., is requesting donations of publications of technical and scientific nature to aid in the rebuilding of its collection, which was destroyed by the Japanese during the war. The library is an office of the Department of Agriculture and Commerce of the Philippines.

Taft Proposal, S. 2143, Providing Federal Aid to States Needing Assistance for Health Activities, Endorsed In Principle by The Council at Meeting, June 9

AT a special meeting on Sunday, June 9, 1946, The Council of the Ohio State Medical Association devoted considerable time to a review of the situation at Washington regarding proposed health legislation.

Special consideration was given to a measure, known as S. 2143, introduced by Senator Robert A. Taft, Ohio, and which has been labelled by the press as a counter-proposal to the Wagner-Murray-Dingell Bill. Copies of the Taft bill had been studied by members of The Council in advance of the meeting.

Based on written opinions of members of The Council, an official statement of policy on the Taft bill and on the health activities and responsibilities of the Federal Government, generally, was formulated and adopted by The Council.

The Council authorized the formulation of a resolution, based on this official statement, for presentation by the Ohio delegation to the A.M.A. House of Delegates which will meet in San Francisco, July 1-5.

Following is the complete text of The Council's statement on S. 2143:

* * *

The Ohio State Medical Association has received requests from its members, and others, for an official expression of opinion on Senate Bill 2143 now pending before the Senate Committee on Education and Labor of the United States Congress.

Senate Bill 2143 was introduced on May 3, 1946, by Senator Robert A. Taft, Ohio, for himself and for Senator Smith, New Jersey, and Senator Ball, Minnesota. The measure carries three titles.

Title 1 proposes the creation of a National Health Agency to be administered by a national health administrator, who must be a doctor of medicine, appointed by the President with the advice and consent of the Senate. It proposes that the following health activities now administered by existing Federal agencies shall be transferred to the National Health Agency: The United States Public Health Service, St. Elizabeth's Hospital, Freedman's Hospital, the Food and Drug Administration, the Office of Vocational Rehabilitation, the Office of Maternal and Child Health (now operating under the Children's Bureau) and the Division of Health Studies in the Bureau of Research and Statistics of the Social Security Board.

Title 2 proposes amendments to the Public Health Service Act. It proposes that the Federal Government assist the states financially in setting up programs to provide general medical and dental services for families and individuals with low income who have insufficient income to pay the whole costs of such services; to provide dental services for school children; and to provide financial assistance for medical, dental, and neuropsychiatric research. An appropriation amounting to $200,000,000 annually for a period of five years for the programs of medical and dental services is proposed. Additional appropriations totalling between $50,000,000 and $60,000,000 for research activities are proposed.. It would create a National Health Council to serve in an advisory capacity.

Title 3 would permit government employes to allow payroll deductions from their salaries and wages for participation in health insurance plans.

* * *

Each member of The Council of the Ohio State Medical Association studied a copy of the Taft-Smith-Ball proposal.

After analyzing and discussing the measure at a special meeting on June 9, 1946, The Council adopted the following statement of policy, referring, generally, to the health activities and responsibilities of the Federal Government and, specifically, to the provisions of Senate Bill 2143:

First: It should be the function of the Federal Government to provide funds only for those services in the field of health which local communities and states are unable to provide for themselves.

Second: Certain states, including Ohio, have sufficient resources to provide adequate health services for their citizens. Such states do not need, and should not expect, financial aid from the Federal Government for such activities.

Third: There are certain areas of the country which are unable through their own limited resources to provide their residents with adequate health services. Therefore, it is apparent that

the Federal Government should be prepared to provide financial assistance to such areas.

Fourth: Should it become necessary for the Federal Government to expand its health activities so as to provide financial aid to local areas and states which are in need of assistance, this should be accomplished through a program which will:

(1) Insure services of a high quality;

(2) Place on state and local governmental agencies the responsibility for administration of the program and permit them wide latitude in administrative functions;

(3) Preclude centralized bureaucratic control and dictation on the part of any official of the Federal Government;

(4) Provide assistance only for those unable to provide themselves or their dependents with essential medical, hospital, and dental services;

(5) Provide for voluntary, rather than compulsory, participation by those eligible for such benefits;

(6) Encourage the continuance and development of voluntary service and insurance plans providing protection against the costs of medical, hospital, and dental services;

(7) Permit each beneficiary of a medical or dental service plan to select his own physician or dentist;

(8) Provide safeguards against extravagance, waste and inefficiency;

(9) Protect the freedom and initiative of professional groups participating in the program;

(10) Allow professional groups directly concerned in providing health services a voice in the formulation of basic policies and regulations and an opportunity to serve in an advisory capacity on administrative details.

Although certain sections of the Taft-Smith-Ball proposal are in need of clarification, in the opinion of The Council of the Ohio State Medical Association this measure, in general, is in accord with the 10 basic principles enumerated above.

Therefore, The Council endorses Senate Bill 2143 in principle, with the following reservations:

1. Modification of certain provisions should be undertaken before it is acted upon by the Congress, with a view toward clarification and for the purpose of insuring even greater safeguards to the authority and responsibilities of those local areas and states which may desire to take advantage of its provisions;

2. Request for assistance provided in the measure should be left to the sole discretion of each state, which shall have the right to decide whether it will participate after evaluating its own needs and resources and the needs and resources of its local areas.

In conclusion, The Council of the Ohio State Medical Association is of the opinion that the State of Ohio has sufficient resources and initiative to provide an adequaate health program for the people of Ohio.

The House of Delegates of the Ohio State Medical Association on May 8, 1946, recommended a 25-point "Health Program for Ohio".

If a program based on these recommendations is put into effect in Ohio—there is no good reason why this can not be done—Ohio will not need assistance from the Federal Government under the provisions of Senate Bill 2143 or any similar proposal. A copy of the 25 recommendations is appended and should be considered as a part of this statement.

(See June issue, *The Ohio State Medical Journal*, pages 620-624 for 25-point program.)

W.R.U. Announces Preventive Medicine Program; New Staff Appointed

Western Reserve University, its school of medicine, and its affiliated hospitals have announced a new preventive medicine program with the appointment of a staff of five medical scientists who will join the institution this Summer.

Dr. John H. Dingle, director of the commission on acute respiratory diseases of the U. S. Army Epidemiological board will serve as chairman, and professor of preventive medicine. Dr. Dingle received the Legion of Merit during the war for his work in the control of respiratory diseases in the armed forces.

The other four appointees, all members of the Army's commission on acute respiratory diseases, are Dr. George F. Badger, former consultant to the Secretary of War in biostatistics; Dr. A. E. Feller, former instructor in the New York University College of Medicine; Dr. C. H. Rammelkamp, former consultant to the Secretary of War; and Dr. R. G. Hodges, former instructor in pediatrics in the College of Physicians and Surgeons, New York City.

All five will come to Cleveland as soon as they can be released from the Army. All are under 40 years of age.

O.P.H.A. Has New Name

The Ohio Public Health Association changed its name to the Ohio Tuberculosis and Health Association during the annual meeting of the organization in Columbus, May 22 and 23.

Officers of the association for the ensuing year, chosen at the meeting, include Dr. Joseph B. Stocklen, Cleveland, president; Dr. Charles A. Neal, Cincinnati, first-vice president, and Dr. Charles A. Doan, Columbus, second-vice president; and Charles C. Stillman, Columbus, secretary.

Names of 88 Medical Officers Added to List of Those Discharged from Services or on Terminal Leave

INFORMATION has been received by *The Journal* showing an additional 88 Ohio physicians have been discharged from military service or have started terminal leave.

The following tabulation lists the names of these physicians, showing the city in which the physician resided or practiced prior to entering the service or the place of his relocation if he has relocated. The rank shown is based on the latest information on file with the State Association. It may not be up to date in some instances.

Name	City	Rank
Adam, Alan B.	Cleveland	1st Lt., A.U.S.
Albanese, Nicholas A.	Columbus	Col., A.U.S.
Ballard, Robert E.	Cleveland	Capt., A.U.S.
Banfield, William S.	Irondale	Lt., U.S.N.R.
Basinger, Norman E.	Elyria	Lt. Comdr., U.S.N.R.
Bayless, Francis	Cleveland	Col., A.U.S.
Beers, George W.	Canton	Capt., A.U.S.
Brandwan, Samuel R.	Cleveland	Capt., A.U.S.
Brunsting, Henry A.	Toledo	Major, A.U.S.
Buckley, C. J.	Cleveland	Capt., U.S.N.R.
Bynum, Frank L.	Cleveland	1st Lt., A.U.S.
Cassidy, Robert H.	Columbus	Lt. Comdr, U.S.N.R.
Couch, Cleon C.	Canton	Major, A.U.S.
Craver, William L.	Columbus	Lt., U.S.N.R.
Craw, Bernard K.	Toledo	Major, A.U.S.
Curtis, George H.	Cleveland	Major, A.U.S.
Decker, Martin	Middletown	Capt., A.U.S.
Denning, Francis J.	Steubenville	Capt., A.U.S.
Espey, Hugh S.	Xenia	Major, A.U.S.
Faessler, Edwin C.	Cincinnati	Capt., A.U.S.
Funk, John A.	Tiffin (formerly of Coshocton)	Lt. Comdr., U.S.N.R.
Gibson, James K.	Tiltonsville	Lt. Col., A.U.S.
Gillespie, David G.	Powhatan Point (formerly of Cleveland)	1st Lt., A.U.S.
Glazer, Alfred	Cincinnati	Lt. Col., A.U.S.
Guthrie, Morris B.	Columbus	Lt. Col., A.U.S.
Hait, Louis	Lorain	Capt., A.U.S.
Harding, Warren G.	Columbus	Lt. Comdr., U.S.N.R.
Haynie, Harold C.	Columbus (formerly of Toledo)	Major, A.U.S.
Hepp, Herman J.	Norwood	Capt., A.U.S.
Hewes, Frederic L.	Fargo, N.D. (formerly of Cleveland)	Capt., A.U.S.
Hillegass, Victor E.	Akron	Capt., A.U.S.
Hoyt, Walter A., Jr.	Durham, N.C. (formerly of Akron)	Capt., A.U.S.
Insel, Herman H.	Dayton	Lt. Comdr., U.S.N.R.
Ireland, Robert B.	Columbus	Capt., A.U.S.
Jacques, Richard H.	Columbus	Major, A.U.S.
Kelley, Warren S.	Cleveland	Lt. (j.g.), U.S.N.R.
Kessel, Sol	Cincinnati	Major, A.U.S.
Kirk, Gilman D.	Columbus	Lt. Col., A.U.S.
Knowlton, Richard S.	Cleveland	Major, A.U.S.
Koehler, R. S.	Dayton	Lt., U.S.N.R.
Krivonos, A. F.	Cleveland	Major, A.U.S.
Kurzner, Meyer	Cincinnati	Comdr., U.S.N.R.
Lehrer, David R.	Columbus (formerly of Sandusky)	Lt. (j.g.), U.S.N.R.
Leigh, A. M.	Cleveland	Capt., A.U.S.
London, McKinley	Cleveland	Comdr., U.S.N.R.
Lytle, Robert P.	Detroit, Mich. (formerly of Cleveland)	Lt. Col., A.U.S.
Maier, Ruben R.	Cleveland	Capt., A.U.S.
Maryanski, William H.	Cuyahoga Falls	Major, A.U.S.
McBride, James M.	Lima	Lt. Col., A.U.S.
McGough, James W.	Columbus	P.A.S., U.S.P.H.S.
Miller, Royston	Cleveland	Lt. (j.g.), U.S.N.R.
Mogg, Albert M.	Columbus (formerly of Youngstown)	Capt., A.U.S.
Neff, Frank R.	Costa Rica, C.A. (formerly of London)	Lt. Col., A.U.S.
Nemrow, Curt M.	Cleveland	Capt., A.U.S.
Nosik, William A.	Cleveland	Lt., U.S.N.R.
Nuss, Robert H.	Cleveland	Lt. (j.g.), U.S.N.R.
Osherwitz, Morris S.	Cincinnati	Capt., A.U.S.
Overs, Paul F.	Spencer	Capt., A.U.S.
Papp, Sandor D.	Alexandria, Virginia (formerly of Dayton)	Lt. Col., A.U.S.
Permut, Samuel R.	Cleveland	Capt., A.U.S.
Phillips, Ralph L.	Columbus	Major, A.U.S.
Picard, Gustav G.	Cleveland	Capt., A.U.S.
Pollock, James H.	St. Clairsville (formerly of Columbus)	Capt., A.U.S.
Reich, Roland A.	Centerville	1st Lt., A.U.S.
Robechek, P. J.	Cleveland	Lt. (j.g.), U.S.N.R.
Ross, Ervin S.	Cincinnati	Lt. Col., A.U.S.
Roush, Carl	Cincinnati	Lt. Col., A.U.S.
Sanderson, Richard J.	St. Louis, Mo. (formerly of Wauseon)	Capt., A.U.S.
Schlueter, Franklin C.	Cincinnati	Capt., A.U.S.
Schonberg, Albert L.	Cleveland	Major, A.U.S.
Schwebel, Samuel	Youngstown	Lt. Comdr., U.S.N.R.
Shoupe, Thomas R.	Findlay	Capt., A.U.S.
Stickley, Louis P.	Cincinnati	Capt., A.U.S.
Stoneburner, Wesley H.	Cleveland	Capt., A.U.S.
Sutton, Myrwood B.	New Philadelphia	Major, A.U.S.
Tamarkin, Samuel	Youngstown	Major, A.U.S.
Tedrow, George C.	Crooksville	Major, A.U.S.
Toomey, Richard S.	Willoughby	Major, A.U.S.
Ward, George J.	Cleveland	Capt., A.U.S.
Warner, Frank M.	Barberton	Lt. Col., A.U.S.
Webb, Walter B.	Ravenn	S.A.S., U.S.P.H.S.
Weller, Eli J.	Cincinnati	Lt. (j.g.), U.S.N.R.
Wiggers, Russell F.	Flint, Mich. (formerly of Cincinnati)	Capt., A.U.S.
Williams, Joseph R.	Eaton	Major, A.U.S.
Yeip, Melvin F.	Cleveland	Lt. Comdr., U.S.N.R.
Zeiders, Glenn W.	Canton	Lt. Col., A.U.S.
Zipf, Robert E.	Dayton	Major, A.U.S.
Zollett, Philip B.	Middletown (formerly of Cleveland)	Capt., A.U.S.

Military News Notes

The Army Commendation Ribbon has been awarded posthumously to Capt. Frank J. Fischer, Cleveland, who was killed in an airplane accident near Leesburg, Va., Sept. 21, 1944. The award is "for meritorious service performed from 14 July, 1944, to 20 September, 1944, as chief of surgical service, Station Hospital, Camp Springs Army Air Base (now Andrews Field), Camp Springs, Md." According to the citation, Capt. Fischer "was personally responsible for organizing, equipping, and administering the surgical service in the newly activated hospital. By his initiative, attention to duty, loyalty, and high degree of professional knowledge and skill, he contributed much to the successful functioning of the medical service as a whole."

* * *

Flight surgeon at the Oberpfaffenhofen Air Depot, 16 miles southwest of Munich, Maj. E. E. McClelland, Bellaire, says Southern Bavaria is "truly beautiful", but he adds: "However, for all the natural beauty, it's a sad country. Cities like Munich show the most disheartening and dismal appearance. The people one sees there show everything on their faces from despair and sadness to sullen defiance."

* * *

Capt. Joseph H. Geyer, Columbus, a paratroop medical officer, has been awarded the Bronze Star, with cluster; the Silver Star, with cluster; and the Purple Heart, with cluster, for liaison

combat jumps in New Guinea and Leyte, and for meritorious action and wounds received in action on Luzon.

* * *

Senior medical officer on the USS Topeka, a light cruiser, is the most recent assignment of Comdr. Robert G. Lehman, Dayton.

* * *

After completing a tour of duty in the Army, Col. Oram G. Woolpert, Columbus, has reverted to civilian status and is now employed by the War Department as Technical Director, Special Projects Division, Chemical Warfare Service, Camp Detrick, Frederick, Md.

* * *

Maj. Rudolph M. Zodikoff, Cincinnati, is on duty at the Station Hospital, Fort Jackson, S. C.

* * *

Dr. Albert B. Sabin, professor of research pediatrics, University of Cincinnati College of Medicine, who was separated from the service as a lieutenant colonel last February, is en route to Japan, as a civilian consultant to the Army Epidemiological Board. He is on a four months' leave of absence from the College of Medicine.

* * *

Col. Howard E. Boucher, chief of the medical section of State Selective Service for over five years, has been awarded the Legion of Merit. He recently resumed private practice in Columbus.

* * *

Change of address: Maj. George H. Wood, Leesburg, Madigan Gen. Hosp., Fort Lewis, Wash.; Capt. Frank L. Shively, Jr., Massillon, 204th Gen. Hosp., Unit 4, APO 246, c/o P. M., San Francisco; Capt. Olan P. Burt, Columbus, AAF Reg. Sta. Hosp., Mitchell Field, N. Y.; Lt. Col. Edward J. Doyle, Columbus, Percy Jones Gen. Hosp., Battle Creek, Mich.; Capt. H. S. Van Ordstrand, Cleveland Heights, Walter Reed Hosp., Washington, D. C.; Lt. John C. Weeter, Cincinnati, Cas. Pers. Sect., AFWESPAC, APO 900, c/o P. M., San Francisco; Capt. Marcel Kahn, Cleveland, 4th Gen. Hosp., APO 1105, c/o P. M., San Francisco; Comdr. W. L. Schafer, Fremont, Wichita, Kan.

* * *

Lt. Col. Frank E. Hamilton, Columbus, has been named chief of the surgical service at Walter Reed Hospital, Washington, D. C. Formerly assistant professor of surgery at Ohio State University College of Medicine, Col. Hamilton has been in the Army Medical Corps since 1942, with service in France, England, Holland, and Germany.

* * *

The Legion of Merit has been awarded to Dr. John E. Hendricks, Newark, for outstanding service at Westover Field, Mass., as a member of the Air Surgeon's Board of Otorhinolaryngology. He directed and administered the Air Forces aero-otitis control program for minimizing the problem of "ear-blocking" which, during training and combat, was found to seriously affect a pilot's efficiency. Separated with the rank of major last April, Dr. Hendricks is now an instructor in the Ear, Nose and Throat Clinic at Johns Hopkins Hospital, Baltimore, Md. He will return to private practice at Newark about July 1.

Capt. Alfred T. Lieberman, who was associated with Dr. Hendricks at Westover Field was similarly cited and awarded the Legion of Merit. A graduate of the University of Cincinnati College of Medicine in 1937, Dr. Lieberman was a resident physician at Johns Hopkins when he entered the Army in 1942. He is now on the staff of the Otological Research Laboratory at Hopkins.

* * *

Maj. H. Charles Schock, Cleveland, has received the Army Commendation Award for meritorious service as chief of the Officer's Tuberculosis Section, Medical Service, Fitzsimons General Hospital, Denver, Colorado. The citation stated that "through his ability and unstinting efforts, and in spite of inadequate and constantly changing personnel, he supervised a service of superior professional effectiveness to the great benefit of the patients at that hospital." Dr. Schock was certified recently by the American Board of Internal Medicine.

* * *

Dr. John A. Knapp, London, has been awarded the United States of America Typhus Commission Medal for meritorious service in connection with the work of the Commission in Burma and Assam during the period from May to November, 1945. Capt. Knapp went overseas with the 69th General Hospital in April, 1944. He was separated from the service in February of this year.

WIN PROMOTIONS

Name	City	Rank
Adler, James S.	Amanda	Capt., A.U.S.
Hamilton, Frank E.	Columbus	Lt. Col., A.U.S.
Schock, H. Charles	Cleveland	Major, A.U.S.
Shively, Franklin L., Jr.	Cleveland	Major, A.U.S.

Courses for Industrial Physicians

Designed for physicians who are engaged in full-time or part-time industrial medical practice, the Wayne University School of Occupational Health is offering a 15-week orientation course in occupational health and medicine beginning September 9. The program is arranged so that enrollment may be made for the entire course or one or more subjects. Further information may be obtained from the dean of the school at 1547 Penobscot Building, Detroit.

VETERANS' INQUIRY DEPARTMENT

Ohio Openings and Locations Sought by Returning Medical Officers; Opportunities Available Listed

THE purpose of this department is to provide space without cost to Ohio veteran physicians for the publication of inquiries they may wish to make concerning an assistantship or residency, a partnership or space in an office, locations and purchase of a practice, purchase of equipment, etc.

The new feature also offers an opportunity for physicians who desire to dispose of their practice or institutions and agencies needing staff physicians to publicize this information for the benefit of service men.

The feature will appear monthly as long as there seems to be a need for it. The regulations governing it are: (1) The veteran submitting the inquiry must be an Ohio physician, i.e., one who was in practice in Ohio when he entered the service or was a native of Ohio but still in training when he entered in the service. (2) Inquiries should not exceed 35 words. (3) Copy must be submitted by the 20th day of the month preceding date of publication. (4) Unless otherwise specified, each inquiry will be carried in two consecutive issues of *The Journal* but no oftener. (5) *The Journal* reserves the right to reject or edit copy submitted; also, to eliminate the new department when and if conditions warrant. (6) Inquiries should be accompanied by full name, forwarding address and identifying data.

OPPORTUNITIES SOUGHT

ASSOCIATION SOUGHT: Discharged Navy medical officer, age 33, thorough training in internal medicine, especially cardiology, graduate of University of Cincinnati, desires association with established internist or group clinic. Will locate in small town in need of internist. Member of Cincinnati Academy of Medicine. V.I.D. No. 15, care of Ohio State Medical Journal.

INTERNIST SEEKS OPENING: Internist, with two and one-half years clinical training, completing American Board of Internal Medicine examinations, age 33, licensed in Ohio, desires association with group or well-established internist. Available after April 1, 1946. V.I.D. No. 16, care of Ohio State Medical Journal.

WANTS SURGICAL RESIDENCY: Veteran medical officer, age 36, with year's internship, year of general residency, two years of general practice and 57 months service in Army as battalion surgeon and 25 months with orthopedic section of general hospital, desires approved residency in general surgery. V.I.D. No. 17, care of Ohio State Medical Journal.

ASSOCIATE PRACTICE SOUGHT: Internist, age 31, graduate of University of Cincinnati College of Medicine, 1938, four years hospital training, including one year cardiac fellowship, eligible for certification by American board, desires association with internist or group. Available immediately. V.I.D. No. 18, care of Ohio State Medical Journal.

PRACTICE WANTED: Obstetrician and gynecologist, discharged medical officer, age 38, desires obstetrical and gynecological practice or association; eligible for American board. V.I.D. No. 19, care of Ohio State Medical Journal.

RESIDENCY DESIRED: A gynecological or surgical residency wanted by returning medical officer, age 42, with three and one-half years hospital training and 10 years general practice; available in March. V.I.D. No. 20, care of Ohio State Medical Journal.

ASSISTANTSHIP WANTED: Discharged Army medical officer desires assistantship with busy general practitioner. Graduate of Northwestern Medical School, 1940; one year rotating internship, Cincinnati General Hospital; special training and degrees in chemistry, physiology and gastroenterology; age 32; single. V.I.D. No. 21, care of Ohio State Medical Journal.

LOCUM TENENS DESIRED: Wanted for three months beginning September 15 by Navy medical officer who will begin residency January 1. Graduate of Harvard Medical School in 1944; aged 26; internship Lakeside Hospital, Cleveland. V.I.D. No. 22.

SEEKS INDUSTRIAL ARRANGEMENT: Veteran with extensive industrial background seeks association with individual or group in this type of practice. Willing to invest. Cleveland area preferred but others also considered. V. I. D. No. 23, care of Ohio State Medical Journal.

ASSISTANTSHIP WANTED: Assistantship to general practitioner or radiologist sought by naval officer to be discharged September 1. Age 28. Ohio license. Graduate of Cincinnati University College of Medicine. Rotating internship. Two and one-half years part-time civilian and two years Navy roentgenology. V.I.D. No. 24.

OPPORTUNITIES OFFERED

GENERAL PRACTICE AVAILABLE: Excellent opportunity immediately for young physician for heavy practice. No other physicians in town of 1,000, located in Northwestern Ohio, surrounded by rich agricultural area. Modern house and separate office available at low rental. Write S.P.C., care of Ohio State Medical Journal.

INTERNS AND HOUSEMEN NEEDED: Good Samaritan Hospital, Dayton, has openings for six interns. Internships approved by American Medical Association. Weekly seminars offered by members of various specialty boards. Also vacancies for four returning veterans as housemen; also entitled to seminars. Stipends for interns $50.00 with full maintenance; stipends for housemen, $150.00 with full maintenance. Contact Intern Committee of hospital.

OPENING FOR GENERAL PRACTICE: Opening in Toledo for young man interested in general practice (surgically inclined) to reopen a former well-established practice. Office completely furnished. Reason: Limiting practice to internal medicine. Excellent location for future group practice. D.O.M., care of Ohio State Medical Journal.

CLINIC STAFF OPENING: Opening for young man interested in general practice on staff of group clinic. Compensation first few months on salary basis; thereafter on percentage basis. All equipment furnished by clinic. L.A.C. care of Ohio State Medical Journal.

PRACTICE AVAILABLE: Practice in Valley City, Medina County 20 miles from Cleveland, in heart of thriving farming and dairy community, available. Physician who located there during war emergency, desires to return to special practice in city. House with combined office available any time. Contact Dr. F. C. Reutter, Valley City, Ohio.

PART-TIME INDUSTRIAL PRACTICE: Good opening for physician interested in part-time industrial practice,

physical examinations, and emergencies. Columbus industrial firm. Write C.W.C., care of the Ohio State Medical Journal.

INDUSTRIAL COMMISSION: Openings available in Medical Section, Ohio Industrial Commission. Consult Dr. Robert André, chief supervisor, Medical Section, State Office Bldg., Columbus.

STATE HOSPITAL STAFF OPENINGS: Staff physicians for various institutions serving the mentally ill, mentally defective and epileptic needed. Physicians who have had some psychiatric training or experience preferred but can offer positions to doctors who may be interested in becoming acquainted with the specialty. Two positions of special importance now open are: Superintendency, Youngstown Receiving Hospital (especially attractive for young physician with residency in psychiatry) and Clinical Directorship, Gallipolis State Institute (fine opportunity for man who has had neuropsychiatric training to become acquainted with those neurological conditions that cause epilepsy in addition to a chance to be a specialist in the field of true epilepsy). Consult Dr. Frank F. Tallman, Ohio Commissioner of Mental Hygiene, State Departments Building, Columbus 15.

PUBLIC HEALTH OFFICERS NEEDED: Several counties in Ohio in need of full-time health commissioners. Those with training and experience, or interested in public health work, may obtain complete details from Dr. Roger Heering, Ohio Director of Health, State Departments Building, Columbus 15.

PRACTICE FOR SALE: Active practice in a community of 3,000, North Central Ohio. Large amount of industrial work in addition to regular practice. Equipment includes new X-ray, diathermy, modern furniture, drugs and supplies. No real estate for sale. Moderate rent. Estimated price $7,500, cash or terms. Will introduce for a short time. Write R.J.S., care of Ohio State Medical Journal.

TUBERCULOSIS HOSPITAL OPENING: Resident physician needed in this institution doing intensive collapse therapy, including surgery. Good opening for man who desires to enter this field of medicine. District Tuberculosis Hospital, Lima; H. H. Brueckner, M.D., superintendent.

VETERANS ADMINISTRATION: Openings for physicians as members of rating boards for either full time or part time duty. Basic salary $4300.00 per annum, with additional compensation for overtime. Contact nearest V.A. office for particulars.

PRACTICE AVAILABLE: General practice at Friendship, Scioto County; seven miles from Portsmouth, which has two hospitals; population of area about 8,000; centralized elementary school; within six miles of High School; two Protestant churches; combined residence and office, with four-acre plot, available for sale or rent; no other physician in community. G.F.J., care of Ohio State Medical Journal.

FULL-TIME RESIDENT PHYSICIAN NEEDED: At Homeplace, Perry County, Kentucky, operated by E. O. Robinson Mountain Fund as educational center for mountain people. Graduate nurse; clinic building being planned; affiliation with medical center in Cincinnati for consultation and specialized services; salary $5,000 per year, with home and transportation furnished. Write Dr. Howard P. Fischbach, 1122 Carew Tower, Cincinnati 2, Ohio.

PRACTICE AND HOME FOR SALE: Active practice established 10 years in town of 2000 with local post office serving 8000. Brick and stone home with modern interior. Has suite of rooms for office. All modern office equipment with stock of drugs and X-ray, diathermy, ultraviolet. Seeing more than 20 patients per day. Physician urgently needed. Forced by service-connected disability to retire from general practice. All is offered to a veteran for price of real estate alone. Liberal terms; can pay for all in three years from earnings. M. R. Wedemeyer, M.D., Oak Hill, Ohio.

Industrial Health Congress

Dr. C. M. Peterson, Secretary of the Council on Industrial Health of the American Medical Association, has announced that the seventh Annual Congress on Industrial Health will be held in Boston at the Copley-Plaza Hotel, September 30 through October 3.

Army and Navy To Supply Medical Officers to V.A.

The War and Navy Departments have announced joint action taken to relieve a serious shortage of medical officers which now exists in the combined requirements of the Army, Navy, and Veterans Administration.

Regardless of date of entry on active duty, only a two-year period of service will, after July 1, be required of all Army Medical Corps Officers, including graduates of the Army Specialized Training Program except critically needed specialists. A two-year period of service will be required for all Navy graduates of the Navy Medical V-12 Training Program, who, after March 1, 1946, were or will be ordered to active commissioned duty upon completion of internship. Navy doctors already separated will not be recalled. Under the Army's new two-year policy, it is estimated that approximately sixty days after July 1 will be required to complete the release of approximately 3,000 Army doctors affected by the change.

By the above action the requirements both of the Army and Navy can be met and in addition the Army can make available to the Veterans Administration approximately 1,000 badly needed Medical officers and the Navy about 500.

Extension of the period of service required for Navy doctors and dentists applies only to those whose education was subsidized by the Federal Government in the V-12 or the ASTP programs.

Hawley Speaks in Cincinnati

Maj. Gen. Paul R. Hawley, medical director of the Veterans' Administration, made the principal address at the thirteenth annual UC Day dinner of the University of Cincinnati, at the Hotel Gibson, Cincinnati, May 2.

General Hawley, who is a graduate of the University of Cincinnati College of Medicine, class of 1914, declared that within the next six months the veterans cared for in hospitals at any given period of time will be doubled. He said that much of the planned increase in efficiency will grow out of the close liaison VA is establishing with medical schools, an affiliation which will be "mutually advantageous".

Dr. and Mrs. Carl G. Braunlin, Portsmouth, now have three daughters who are physicians. Their youngest daughter, Mrs. Janet Hugenberg, recently passed the State Medical Board examinations and is an intern at Cincinnati General Hospital. Dr. Ruth Braunlin Bennett and her husband, Dr. Paul Bennett, have their office in Portsmouth. A third daughter-doctor, Mrs. Marie Braunlin Rogowski, is with her husband who is stationed at Ft. Hamilton, N. Y.

Letter of Commendation Sent To Members of P. and A. Committee

Dr. Robert Conard, Wilmington, who served as Ohio chairman for the Procurement and Assignment Service for Physicians during World War II, has sent a letter to the following physicians who served with him on the Ohio committee, expressing formal appreciation for the excellent work which they did, and sharing with them the thanks which has been expressed by Dr. Frank Lahey, chairman of the Directing Board of the Procurement and Assignment Service, the Surgeon General of the Army and the Surgeon General of the Navy:

Dr. Charles E. Hauser, Cincinnati; Dr. M. D. Prugh, Dayton; Dr. Frank Wiseley, Findlay; Dr. Dale Wilson, Toledo; Dr. James N. Wychgel, Cleveland; Dr. Charles A. LaMont, Canton; Dr. Carl A. Lincke, Carrollton; Dr. Blaine R. Goldsberry, Athens; Dr. Harry F. Rapp, Portsmouth; Dr. John H. Mitchell, Columbus; and Dr. Charles R. Keller, Mansfield.

Dr. Conard's letter, commending members of the committee, read in part as follows:

"Acknowledgment and formal thanks for your loyal and patriotic service on the War Participation Committee has been delayed until final notice from Washington of the termination of the Procurement and Assignment Service. This has just been received.

"During the past four years, in my capacity as Ohio Chairman for Physicians, it was necessary for me to call on you on many occasions for advice on conditions in your District. Often these calls involved difficult decisions and made your position acutely uncomfortable for local reasons. The steady support and sound counsel which you and all the District Committemen gave at all times made possible the successful carrying out of the mission of Procurement and Assignment in Ohio.

"Because you and the other members of the War Participation Committee have, each in your own way, had so large a part in this undertaking, I want to pass on to you some of the expressions of appreciation which have come from those in Washington who carried the staggering burden of the conduct of the war.

"Dr. Frank Lahey writes '... For the Directing Board as its Chairman, I wish to express ... our appreciation for your efforts.... Your undertaking was a difficult one, meeting justly, as you did, both the requirements of the military forces and the home front.... The part you have played in this will never be adequately appreciated, except by those of us who know the contribution you have made. . . . There will be many who have worked with you with whom it will not be possible to communicate directly, and yet without them the ultimate accomplishment would have been impossible. I hope for the Board that you will express to all the various members of your group. our appreciation for their untiring efforts, kind tolerance and successful accomplishment. For the Board, and for me personally, you have our deepest thanks.'

"As a formal acknowledgment, Dr. Lahey enclosed a certificate in 'recognition of uncompensated service during World War II, in the interest of meeting both military and civilian needs. This service represents an outstanding demonstration of military and civilian cooperation for the successful solution of complex wartime problems.' This was signed by the President and by the Surgeons General of the Army, Navy, and U. S. Public Health Service,

"In addition, personal letters from General Kirk and from Admiral McIntyre expressed deep appreciation on the part of the Army and Navy for the work of our Committee.

General Kirk writes 'With no thought of personal reward or remuneration other than the satisfaction which comes to those whose desire it is to assist the nation in time of emergency, you have given freely of your time and professional knowledge to the end that the medical personnel needs of both the military establishment and the civilian population might be adequately met.... I extend the sincere thanks of both the Army Medical Corps and the entire Medical Departments.....'

"Admiral McIntyre writes ' . . . very few are cognizant of the enormous amount of work involved in connection with the duties of the Procurement and Assignment Service, and the fact that these duties were performed on a voluntary basis with no financail remuneration . . . a distinguished service which had a considerable effect on the war effort. The Medical Corps of the Navy joins me in expressing sincere appreciation and a 'well done' for your splendid work and assistance to the Bureau of Medicine and Surgery. . . .'

"I am sure that you will be gratified to have such commendation from those who assigned us this task. I hope that you will find a way to see that the members of your County Committees share this with you."

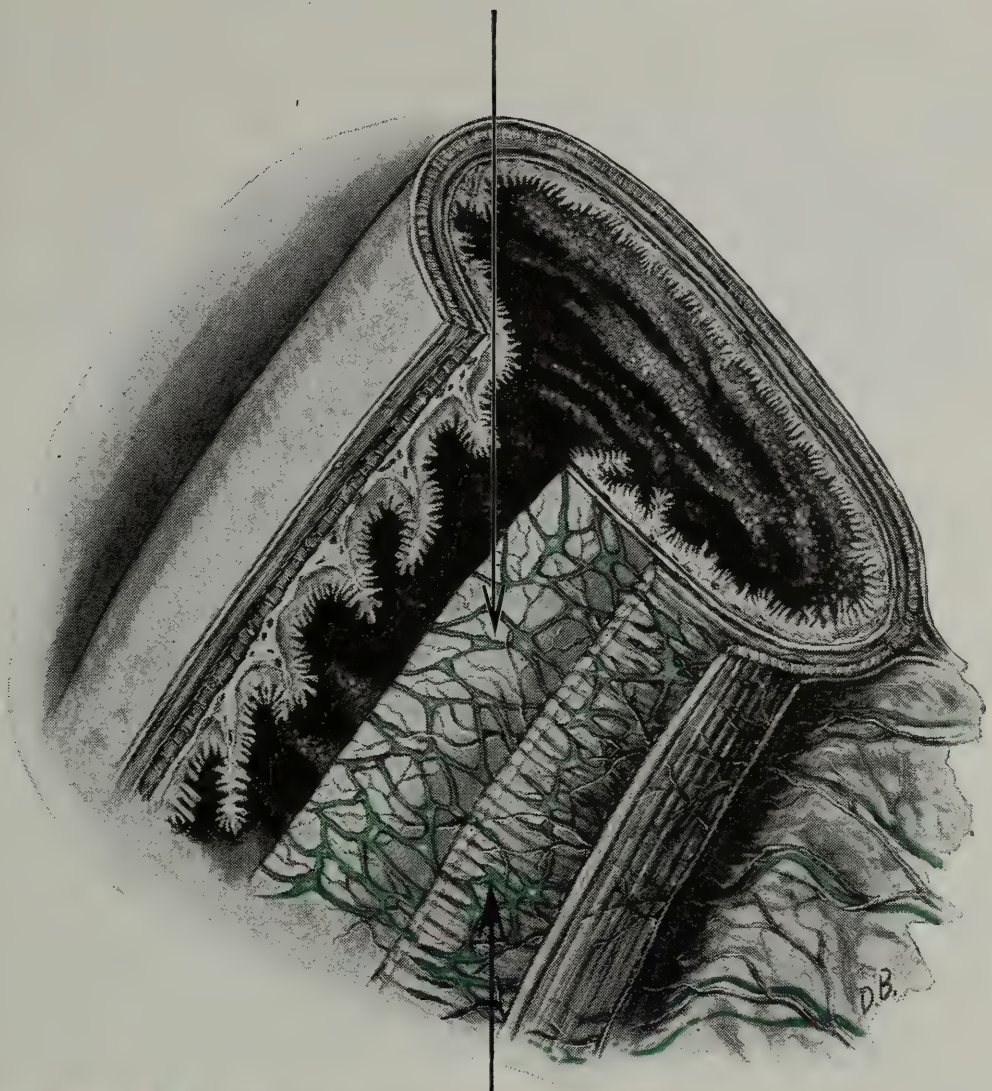
Television Now Used by A.M.A. in Public Education Programs

Following its policy of utilizing every available means for informing the public on health questions, the Bureau of Health Education of the American Medical Association is sponsoring a series of telecasts on WBKB, Chicago's television station.

"Television should be a particularly useful medium for the demonstration type of educational program", Dr. W. W. Bauer, director of the Bureau said. "Television makes possible demonstration and exhibit, appealing to the visual and to the auditory pathways to the brain. Procedures difficult to describe by word of mouth alone can be visually demonstrated by bringing before the camera such procedures as the taking of blood pressure, bandaging, first aid, blood counting, and the use of X-rays".

While the television audience in the Chicago area is limited, Dr. Bauer said it is believed the programs will prove the efficacy of television in conveying important messages of health and good living to the general public in a new manner.

"Methods and technics", he said, "can be developed so that the medical profession will be ready in the future to make use of this new medium as it has used older mediums, such as the radio and the printed page, effectively."



smoothage

stimulates the plexus of Auerbach and Meissner by gentle distention of the bowel wall, initiating reflex peristalsis and movement of the fecal mass.

metamucil

the highly refined mucilloid of a seed of the psyllium group, Plantago ovata (50%), combined with dextrose (50%) as a dispersing agent—provides smoothage for the physiologic management of constipation.

Metamucil is the registered trademark of G. D. Searle & Co., Chicago 80, Illinois.

searle

RESEARCH IN THE SERVICE OF MEDICINE

ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

WE HAVE THE PROGRAM; NOW FOR SOME ACTION

The action of the House of Delegates of the Ohio State Medical Association at the Centennial Anniversary Meeting in May in promulgating "A Health Program for Ohio" (see June issue, *The Journal*, for text) is regarded by many as the most forward-looking, aggressive, and constructive actions and pronouncements in the history of the Association.

Statements of commendation have been received from physicians, health officials, health organizations, and many lay groups.

Of particular interest was the action taken by the Section on Public Health and Preventive Medicine of the Ohio State Medical Association reading as follows:

"At the centennial anniversary meeting of the Ohio State Medical Association on May 9th, 1946, the Public Health and Preventive Medicine Section in one of the largest section meetings in recent years discussed the "Health Program for Ohio".

"It was the unanimous opinion that this is one of the most progressive and far-reaching steps ever taken by the Association.

"It puts the physicians of Ohio on record and solidly back of these varied health needs which are of tremendous interest to the people of the State at this time.

"It indicates a oneness of the private practitioner with the public health doctors in these broad matters so vital to the public health.

"It is the studied opinion of this Section that this action is far in advance of the thinking of other State Associations and serves to put Ohio physicians in a much more favorable position before the public.

"It was therefore recommended that the officers, staff, and house delegates of the Ohio State Medical Association be commended for their stand as stated in "Health Program for Ohio". The members of the Section of Public Health and Preventive Medicine are proud to be members of the Ohio State Medical Association."

Every member of the Association should study "A Health Program for Ohio" if he has not done so. That's Step No. 1.

The $64 question is: Now that we have the program on paper, what are we going to do about putting it into effect?

That's something for each member, each county medical society, each officer and committeeman of the State Association to consider. A few willing hands and a lot of lip service will not be enough. The aggregate brains of the medical profession of Ohio, health officials, health workers, government officials, and the public of the State will be required to produce the plans and methods for putting the program to work in Ohio.

Unless Ohio does do just that, somebody else is going to step into Ohio's corner. Your guess as to whom is probably correct.

ARE WE GOING TO BE MICE OR MEN ?

"City health officials claim they will be shortchanged by an impending 40 per cent cut in Federal funds allocated to Cleveland's venereal disease control program", states the *Cleveland News*.

The article points out that Uncle Sam wants to "cut its ante" from $50,000 to $30,000 and that this will "wreck" the local program for which Cleveland has been spending $200,000 in local funds, according to Cleveland officials.

The News contends that Cleveland officials want the Governor and state health officials to "gang up" on Washington to try to get the full "handout".

Then it draws this moral: "City Health Department should stand on its own feet, side-step outside subsidies, fight for adequate appropriations of its own for the No. 1 job Cleveland expects to do".

Better advice has never been offered.

Here again is a sample of the same old story: Local subdivisions wanting their cake but also wanting to eat it. Instead of trying to stand on their own feet, they scamper to Washington to get a handout from the Great White Father and then wail when some brass hat at Washington starts telling them how to run their affairs.

Imagine! Cleveland of all places begging for help from the Federalcrats!

Isn't it about time for Cleveland and all the other cities and counties and townships of Ohio—in fact the great State of Ohio—to stop being tramps?

Is Ohio a sovereign state or isn't it?

If it is, it's about time to prove it!

IT'S THE FOLLOW-THROUGH WHICH REALLY COUNTS

Across the desk recently came a sample copy of a revised edition of the Metropolitan Life Insurance Company's pamphlet on "Tuberculosis".

In a letter accompanying the folder, Dr. Donald B. Armstrong, second vice-president in charge of health and welfare activities, makes these pertinent and significant statements:

"We have endeavored to keep tuberculosis epidemiological factors and control methods in

Information! —ABOUT THE NEW



Campbell's STRAINED BABY SOUPS

Q. What are the ingredients in Campbell's Strained Baby Soups?

A. Campbell's use carefully selected meats, cereals and those vegetables scientifically recognized as having the most desirable nutritive qualities. All the food properties are natural. Because Campbell's are accustomed to purchasing only selected meats and vegetables, the best is assured for Campbell's Strained Baby Soups.

Q. What about vitamin and mineral retention?

A. The latest scientific information has been drawn upon in the development of a cooking method to insure the effective conservation of vitamins and retention of minerals.

Q. When should Baby be started on strained soups?

A. Campbell's Strained Baby Soups can be started as early as any strained baby foods. Depending upon the baby, pediatricians recommend beginning between the ages of three and six months.

Q. What about the flavor of Campbell's Strained Baby Soups?

A. Every mother wants her baby's food to be palatable. Campbell's preparation and cooking methods have been devised to retain natural flavors insofar as possible. Babies develop food preferences early, accept some foods, reject others. Their acceptance of Campbell's Strained Baby Soups is indicated by the increasing demand for these soups wherever they have been introduced.

A comprehensive analysis of each soup may be had upon application to Campbell Soup Company, Camden, New Jersey.

5 KINDS:

LIVER
CHICKEN
LAMB
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VEGETABLE

All in Glass Jars



Campbell's Strained Baby Soups represent fine quality . . . in ingredients . . . in care and method of cooking . . . in retention of minerals and conservation of vitamins . . . and in good flavor. Every resource of Campbell's Kitchens is devoted to that aim.



LOOK FOR THE RED-AND-WHITE LABEL

proper perspective. It is unfortunate that in much popular literature concerning tuberculosis today there appears to be some relative overemphasis upon the X-ray and upon mass case finding procedures. These approaches alone, without more effective follow-up, will not solve the problem. Control measures still depend largely upon the private or clinic physician, his examination of family contacts, his interpretation of technical and laboratory findings, and the proper use of therapeutic facilities."

This being true, a great responsibility rests on the attending physician. Unless he plays his role efficiently, the total job won't be done.

After the X-ray findings are placed in his hands, the physician should fully understand that successful disposition of the case will depend on how well he follows through.

Like the physical examination, the X-ray survey is only the preliminary step. It's the follow-up and follow-through which really counts.

A SURE WAY NOT TO INCREASE NUMBER OF PHYSICIANS

We note that Assistant Secretary of Agriculture Charles F. Brannan has appealed to Congress to enact the Wagner-Murray-Dingell Bill, contending that it will aid rural areas in getting better medical and health services.

But, with the inconsistency which we have come to expect from most of the follow-the-leader boys at Washington, Mr. Brannan states that the most crying need in rural America is for doctors, dentists, and other health personnel.

To date, no one has succeeded in pointing to a single provision of the W-M-D measure which will increase the number of doctors, dentists, and other health personnel.

In fact, under a program such as the one proposed by Messrs. W-M-D there is reason to believe there will be fewer doctors and dentists and health personnel. That proposal, if it does anything, removes most of the incentives for entering the medical and health professions, unless, of course, the youth of America have come to the point where all they want are three meals a day, an eight-hour, five-day week, and a roof over their heads, which we don't believe is the case—yet.

HISTORY AND HISTORY IN THE MAKING

Quote: "It has been a long fight to put the control of our economic system in the hands of the Government, where it can be administered in the interests of the people as a whole."—*Mrs. Eleanor Roosevelt in "My Day".*

Quote: "On October 18, 1936, Hitler appointed Goering to control the whole economic life of the country."—*"How Nazi Germany Has Controlled Business", by L. Hamburger.*

Quote: "We see thus the Fascist State resolutely enter the economic field to dictate what shall be from now on the relationship between capital and labor, employer and employee, landowner and farmhand, industrialist and worker." —*"The Philosophy of Fascism", by Mario Palmieri.*

Quote: "Rome passed from freedom to serfdom".—*"Caesar and Christ", by Will Durant.*

INDUSTRIAL NURSE AND THE PLANT DOCTOR

Too many physicians who direct on a full-time or part-time basis the medical activities in industrial plants are refusing to prepare, sign, and administer standing orders for industrial nurses, according to the Committee on Education of the American Industrial Nurses' Association.

This situation can not be tolerated. The nurses rightfully charge that without such orders they are often called to perform services for which they are not prepared or which they are not legally entitled to perform.

Every Ohio physician who supervises the medical activities of a plant where a nurse is employed should issue written orders to the nurse in individual cases or work out a set of standing orders which will operate in all cases.

This is the only way proper professional relations can be maintained and the only way the interests of patient, nurse, and physician can be adequately protected.

The Committee on Industrial Health of the Ohio State Medical Association has adopted a set of standing orders for nurses employed in industry. This uniform guide, which can be applied in cases where specific written orders are not issued by the physician, can be used by any physician as the basis for an understanding with the nurse or nurses in the plant or plants under his supervision.

It's time to straighten out this situation.

RESPONSIBILITY OF PHYSICIAN VITAL IN DOG-BITE CASES

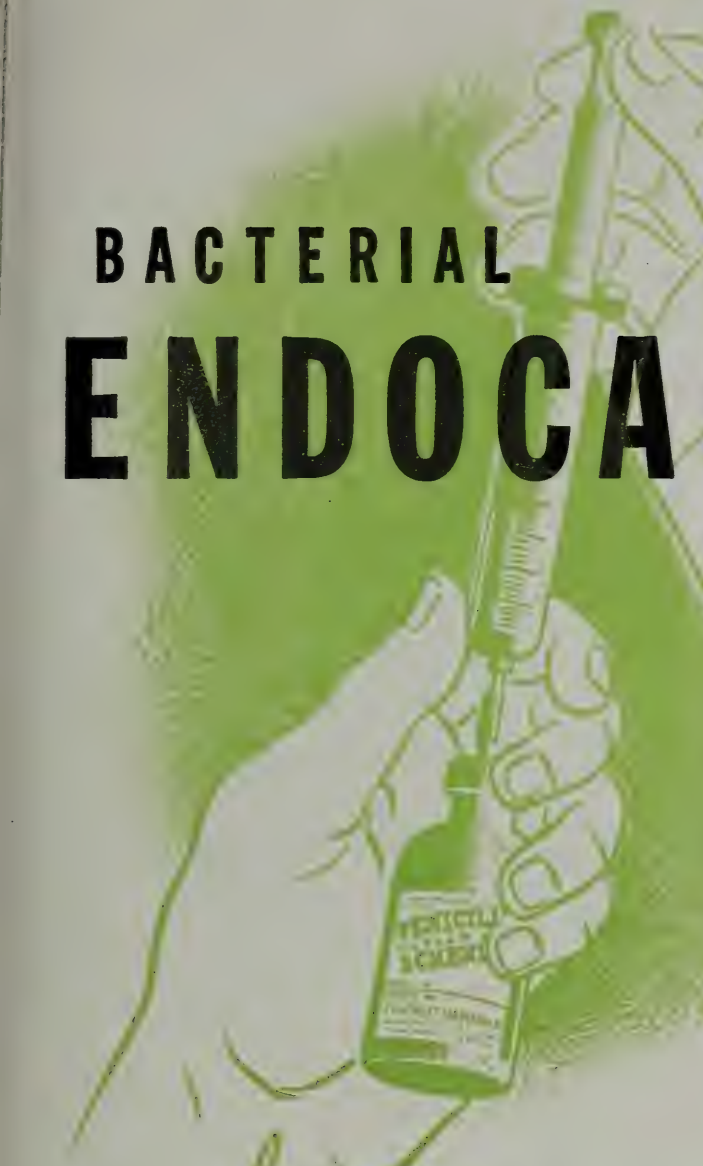
Rabies in dogs has been prevalent in Ohio for the past few years. This Summer appears to be no exception. Recently a girl died from rabies in Cincinnati.

The reporting and treatment of dog bites are vital responsibilities of a physician called to attend a person who is bitten. Team work between the physician and the local health department is necessary for the proper handling of these injuries.

Prompt reporting of all persons bitten by dogs to the local health department is required under Regulation 2b of the Ohio Sanitary Code. The report should be made by the attending physician, a hospital, a dispensary, by the person bitten, or anyone having knowledge of the facts.

Under present procedure a biting dog is to be kept isolated for at least 10 days. If clinical

BACTERIAL ENDOCARDITIS



No. 1 in Schenley Laboratories' continuing summary of Penicillin Therapy

Penicillin is the best agent available for the treatment of subacute bacterial endocarditis. Daily administration of 200,000 to 300,000 units or, in infections with resistant organisms, much more, in divided doses (every 3 hours) is required. Intramuscular injections are usually the route of choice; however, in certain instances, it may appear desirable to employ continuous drip. Therapy should be continued for a minimum of 3 weeks and must be continued until the blood cultures are consistently negative. Penicillin alone is as effective as penicillin and heparin combined.

Final determination of cure depends upon long-term observation, but if the patient remains asymptomatic and bacteriologically free for a period of 4 weeks after cessation of penicillin therapy, the prognosis for complete cure is excellent. However, it must be remembered that valvular damage and renal lesions are not favorably influenced.

DAWSON, M. H., AND HUNTER, T. H.: *The Treatment of Subacute Bacterial Endocarditis with Penicillin: Results in Twenty Cases, J.A.M.A. 127:129 (Jan. 20) 1945*... FAVOUR, C. B.; JANEWAY, C. A.; GIBSON, J. G., II, AND LEVINE, S. A.: *Progress in the Treatment of Subacute Bacterial Endocarditis, New England J. Med. 234:71 (Jan. 17) 1946.*

BEFORE YOU DECIDE ON THE PENICILLIN OF YOUR CHOICE

Consider this important fact: For many years, Schenley has been among the world's largest users of research on mycology and fermentation processes... from which penicillin and other antibiotics are derived. The wide scope of our activities in these fields is your assurance that when you choose Penicillin Schenley you choose a product thoroughly tested for potency and quality.

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signs of rabies have not appeared by that time it is certain that the dog's saliva was non-infectious for rabies at the time of the bite although he may subsequently develop the disease.

There is a severe penalty, including fine and imprisonment, or both, for failure on the part of anyone in not reporting a dog bite. This is provided in Sec. 4414 of the General Code.

Dog bites, according to recognized authorities, should be treated immediately with fuming nitric acid or 40 per cent formalin. Delay lessens the effectiveness of the nitric acid but it remains partially effective up to 48 hours after the bite.

Where bites involve the head and face give antirabic treatment. It can be discontinued after ten days if the dog is normal. Silver nitrate, phenol, and all ordinary antiseptics have little value in the prevention of rabies.

Surgical procedures such as incision or débridement may be useful adjuncts to cauterization. Preliminary washing with soap and water should be employed.

The period between infected bite and development of rabies varies from one week to six months, depending on the location of the bite. The incubation period is shorter when the bite is on the face.

Under the following circumstances all persons bitten should be immunized by the Pasteur method:

1. When the biting animal has been diagnosed as rabid either clinically or by laboratory methods.
2. When a person has had close contact with a rabid animal even though he has not actually been bitten.
3. When there is any uncertainty concerning the health of the dog. This situation occurs when the dog is a stray or escapes and cannot be observed for ten days.
4. Treatment should be started immediately if the face has been bitten but may subsequently be discontinued if clinical observation shows the dog to be in good health. A negative laboratory report does not exclude rabies.

The Pasteur treatment should not be given carelessly or indiscriminately. If there is no reasonable indication that the animal with which the person has been in contact is rabid, treatment should not be applied.

Vaccine for the usual 14 treatments, or more if the physician thinks necessary, for serious bites, may usually be secured from the county health departments. Indigent patients may have the vaccine administered by arrangement with the health officer.

LOCAL MEDICAL BULLETIN STARTED BY MONTGOMERY COUNTY SOCIETY

The Montgomery County Medical Society deserves congratulations for initiating an official publication—*The Montgomery County Medical Society News*—Volume 1, No. 1 of which is dated June 1, 1946.

The bulletin will be published monthly, except in August.

Issue No. 1 is a peppy, snappy edition, with a liberal supply of advertising.

Editor of this newest entry into the field of local medical journalism is Dr. Reid P. Joyce. The associate editors are Dr. Lynn Baker, Dr. Richard Hochwalt, and Dr. Clarence Derby. Mr. Frank C. Bateman is serving as business manager.

We extend to *The Montgomery County Medical Society News* our best wishes and offer it our active cooperation.

Backlog of Requests for Hospitalization Eliminated in Ohio, V.A. Reports

The Veterans Administration has wiped out a backlog in the number of war veterans with service-connected disabilities who were awaiting hospitalization in Ohio, Michigan, and Kentucky.

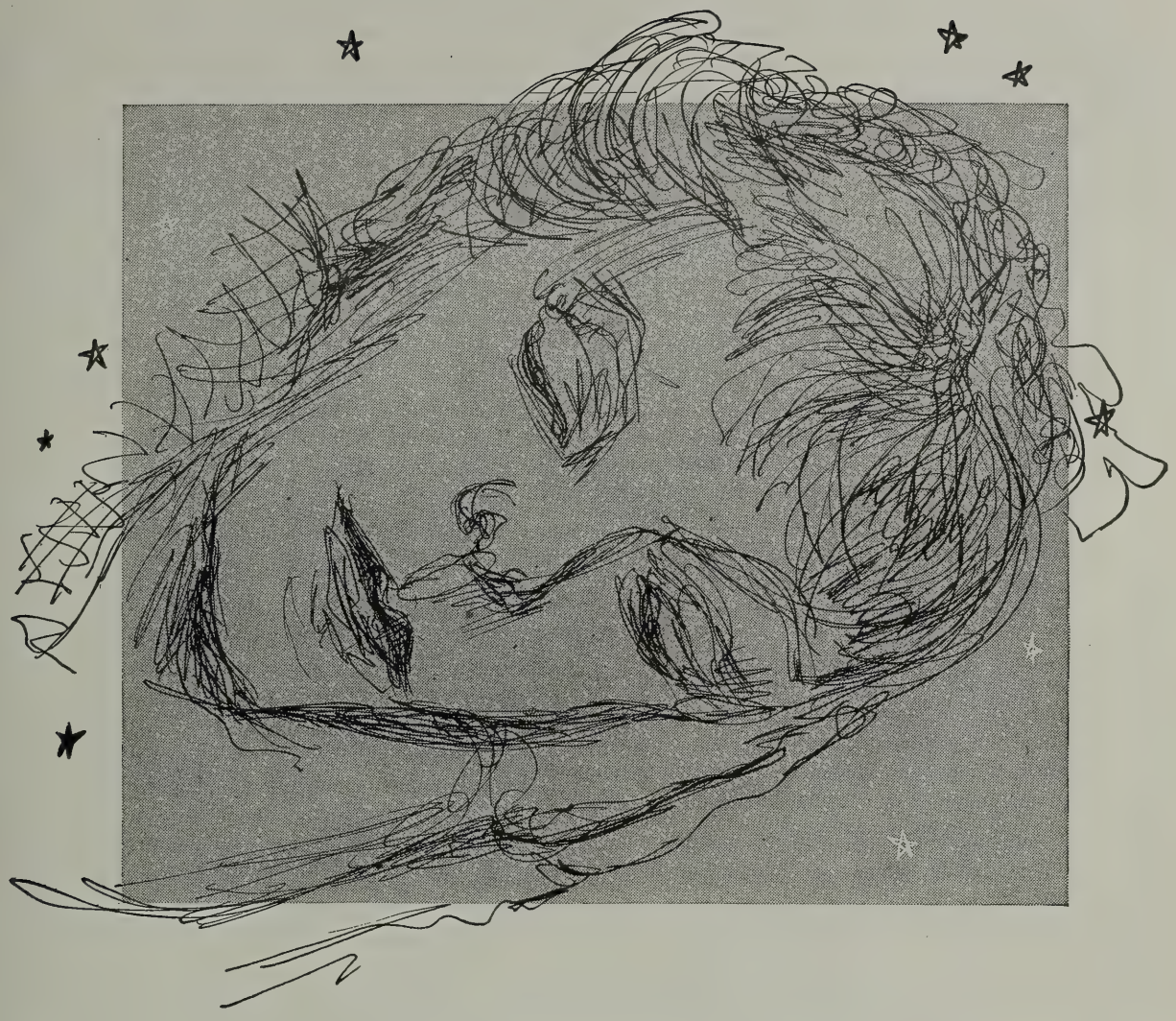
The Columbus Branch Office for the three states has reported that immediate hospital care now is provided veterans requiring such treatment as a result of wounds or injuries incurred while in service.

On May 1, 230 service-connected cases were awaiting admission to Veterans Administration hospitals in the three states. An immediate reduction in the backlog was ordered by the Columbus Branch Office and the last 10 of these have been admitted to hospitals.

Medical officials at the Columbus Branch Office said every possible effort will be made to keep hospitalization of such cases on a current basis. If Veterans Administration hospitals in the three states are unable to provide immediate care for veterans with service-connected disabilities, private hospitals will be utilized and the expense paid by the Veterans Administration.

The eight hospitals operated by the Veterans Administration in the three states are caring for approximately 9,100 patients, of which approximately 2,500 are veterans with service-connected disabilities, having first priority for hospitalization. Approximately 2,600 veterans with disabilities which were not incurred in service now are awaiting hospitalization and will be admitted when beds are available.

Released recently from military service, Dr. Earl Kleinschmidt, formerly health commissioner of Toledo, has been named director of the Tuberculosis Institute of Chicago and Cook County.



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Healing sleep is one of the most effective therapeutic agents. But when clinical conditions alter sleep habits, adequate rest may be most difficult to secure.

When sleep patterns of your patients are altered, 'DELVINAL' *sodium vinbarbital* will provide a night of restful sleep, in the majority of instances, with relative freedom from unpleasant side-effects of excitation or "hangover."

'DELVINAL' *sodium vinbarbital* is a mild sedative that has a relatively short induction period and a moderate duration of action.

Council-accepted, it may be prescribed for the relief of insomnia, for general sedation, preanesthetic hypnosis, psychiatric sedation, obstetric amnesia, and for numerous purposes in the field of pediatrics. Supplied in 32-mg. (½-gr.), .10-Gm. (1½-gr.), and .20-Gm. (3-gr.) capsules.

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In Memoriam

Charles W. Albright, M.D., Detroit, Michigan; Starling Medical College, Columbus, 1897; aged 85; died April 24. Dr. Albright practiced in West Mansfield, Logan County from the late '90's until 1913. He is survived by a daughter.

Ellis Robert Bader, M.D., Cincinnati; University of Cincinnati College of Medicine, 1913; aged 58; died June 16; member of the Ohio State Medical Association; Fellow of the American Medical Association; First Vice-President of the American Roentgen Ray Society; certified by the American Board of Radiology; member of the Radiological Society of North America, Inc., and the American College of Radiology. Dr. Bader was former assistant professor of radiology at his alma mater and was on the staffs of Christ, Deaconess, Bethesda, and Children's Hospital in Cincinnati. He was a veteran of World War I, and had lived and practiced in Cincinnati since 1913. His widow, a daughter, a son, and a sister survive.

Frank M. Baldwin, M.D., Hilliards; Toledo Medical College, 1900; aged 75; died May 15. Dr. Baldwin had practiced medicine in Marion for about 20 years previous to his retirement. Surviving are his widow, a son, and a daughter.

John W. Boss, M.D., Birmingham; Western Reserve University School of Medicine, 1902; aged 76; died May 18; member of the Ohio State Medical Association and Fellow of the American Medical Association. Dr. Boss had practiced medicine in Birmingham for 42 years and was for 30 years an active member of the Lorain County Medical Society. He was voted to honorary membership in the society upon his retirement from practice three years ago. Active in civic affairs, Dr. Boss was a member of the Methodist Church and the Masonic Order. He taught a Red Cross class for several years and was active in church and school building programs in Birmingham. Survivors are his widow and a daughter.

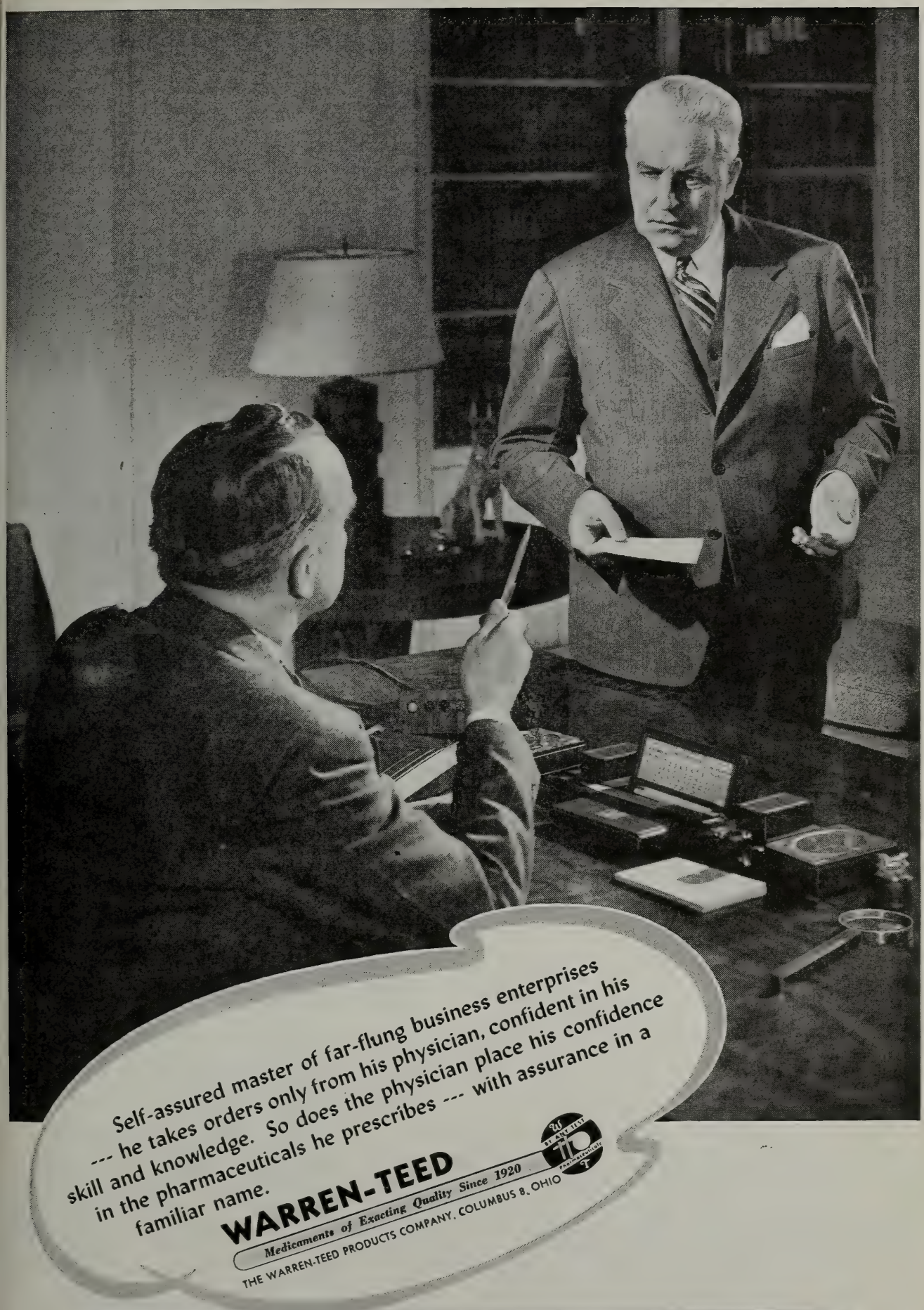
Shepard H. Burroughs, M.D., Ashtabula; Western Reserve University School of Medicine, 1904; aged 65; died May 17; member of the Ohio State Medical Association; Fellow of the American Medical Association; Fellow of the American College of Surgeons. Dr. Burroughs had practiced medicine in Ashtabula for 41 years and was president of the Ashtabula County Medical Society in 1918. He was past-president of the Ashtabula General Hospital staff, and for many years a lecturer on surgery before students of the institution's school of nursing. He was affiliated with the Episcopal Church, the Elks, Moose, and Masonic lodges, and a former member of the Ohio National Guard Hospital Corps. Surviving are his widow, three daughters, two sons, one of whom is Dr. Shepard A. Burroughs of Ashtabula, a sister, and two brothers.

Frank Marion Coppock, M.D., Cincinnati; University of Cincinnati College of Medicine, 1914; aged 59; died May 9; member of the Ohio State Medical Association and the American Medical Association. Dr. Coppock had served as Hamilton County coroner since 1934, and was professor of gynecology at the University of Cincinnati College of Medicine. He was on the staff of Christ Hospital; a member of the board of governors of the Cincinnati University Club; member of the Methodist Church and Masonic Lodge; and president of the Oak Building and Loan Company. A stamp collector, Dr. Coppock was a past president of the National Philatelist Society. His widow and two sisters survive.

William F. Dager, M.D., Washington, D. C.; University of Pennsylvania School of Medicine, Philadelphia, 1897; aged 74; died June 2; former member of the Ohio State Medical Association and the American Medical Association. Dr. Dager had practiced medicine in Lorain for 20 years and in several other northern Ohio cities. He later became affiliated with the Veterans Administration. After retiring in 1941 to live in Washington, D. C., he was called into the service by the Administration during World War II, and was retired again only recently. His widow and a daughter survive.

Louis P. Diehl, M.D., Woodsfield; Starling Medical College, Columbus, 1882; aged 87; died May 11; former member of the Ohio State Medical Association and Fellow of the American Medical Association. Dr. Diehl began his practice of medicine in Monroe County about 1882. One son and three daughters survive.

Stanley D. Giffen, M.D., Toledo; Columbia University College of Physicians and Surgeons, New York, 1902; aged 72; died May 5; former member of the Ohio State Medical Association and Fellow of the American Medical Association; certified by the American Board of Pediatrics and member of the American Academy of Pediatrics. Dr. Giffen was former chief of staff of Maumee Valley hospital, and was a child specialist in Toledo from 1919 until his retirement in 1942. Interested in the study of tuberculosis, he was chairman of the Toledo Christmas Seal drive in 1928, and visited Switzerland several times to observe studies of tuberculosis of the bone. He also studied in London and Vienna. Before the first World War, during which he was in charge of an Army Hospital in Panama, he had practiced med-


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icine in New York City and Mexico City, Mexico. His widow survives.

Frank H. Hassler, M.D., Attica; Hahnemann Medical College and Hospital, Chicago, 1885; aged 92; died May 18. Dr. Hassler practiced medicine in Seneca County for over 50 years. He was a member of the Masonic Lodge.

Alan Fesch Knisley, M.D., Lima; Medical College of Ohio, Cincinnati, 1884; aged 87; died June 12. Dr. Knisley had practiced medicine in Chicago, Uhrichsville, and Lima. He retired from the practice of medicine in 1909. Surviving are two sons, including Dr. Alan D. Knisley of Lima, and a sister.

Hiram Edgar Pintler, M.D., Peoria, Illinois; Hahnemann Medical College and Hospital, Chicago, 1895; aged 77; died Apr. 24. Dr. Pintler had formerly practiced medicine at St. Marys. His widow survives.

Harold Oliver Ruh, M.D., Cleveland; Western Reserve University, 1910; aged 62; died May 18; member of the Ohio State Medical Association; Fellow of the American Medical Association; certified by the American Board of Pediatrics and member of the American Academy of Pediatrics. Dr. Ruh was chief pathologist at Lakeside Hospital and later resident physician at Babies' and Children's Hospital prior to World War I. During that war he served, with the rank of major, in the Army Medical Corps and at its close he returned to Cleveland to specialize in pediatrics. He had practiced medicine in Cleveland for a total of 30 years. His widow, two sons, and a brother and sister survive.

Robert Ray Sattler, M.D., Cincinnati; Medical School of Harvard University, 1916; aged 58; died May 20. Dr. Sattler served with both the British and U. S. Army Medical Corps in World War I. Surviving are his widow, two sons, a daughter, and three sisters.

George H. Shawaker, M.D., Columbus; Ohio Medical University, Columbus, 1902; aged 66; died May 21; former member of the Ohio State Medical Association and the American Medical Association. Dr. Shawaker was a practicing physician in Columbus from 1912 until 1939, when he joined the staff of the Columbus State School, where he served until the time of his death. He was a member of the Masonic Lodge.

Warde Byron Smith, M.D., Frankfort; University of Cincinnati College of Medicine, 1913; aged 58; died May 16; member of the Ohio State Medical Association and Fellow of the American Medical Association. Dr. Smith was a delegate from the Ross County Academy of Medicine in 1936-1937, and president of the Academy in 1938-1939. He was the holder of the Distinguished Service Cross, having been decorated during World War I, in which he served as a captain in the Army Medical Corps. Except for the period of the first war, Dr. Smith practiced medicine in Frankfort from 1913 until the time of his death. He was a member of the Presbyterian Church, the Masonic Lodge, and the American Legion. His widow, a daughter, and three brothers survive.

George Weiss, M.D., Ragersville; Ohio Medical University, 1895; aged 82; died May 16. Dr. Weiss had practiced medicine in Tuscarawas County for 51 years. His widow, a daughter, a brother, and a sister survive.

Wayne Addison Yoakum, M.D., Homer; Harvard Medical School, 1920; aged 52; died May 11; Fellow of the American Medical Association. Dr. Yoakum had practiced in Detroit from 1922 until 1939 and in Miami Beach, Florida from 1939 until 1941, when he entered practice at Homer in Licking County.

COMING MEETINGS

Ohio State Medical Association, Cleveland, May 6-8, 1947.

American College of Surgeons, New York City, Sept. 9-13.

American Congress of Physical Medicine, New York City, Sept. 4-7.

American Dietetic Association, Cincinnati, Oct. 14-18.

American Public Health Association, Cleveland, Nov. 12-14.

American Roentgen Ray Society, Cincinnati, Sept. 17-20.

American Urological Association, Cincinnati, July 22-25.

Interstate Postgraduate Medical Association, Cleveland, Oct. 15-18.

Mississippi Valley Medical Society, Sept. 25-27, St. Louis.

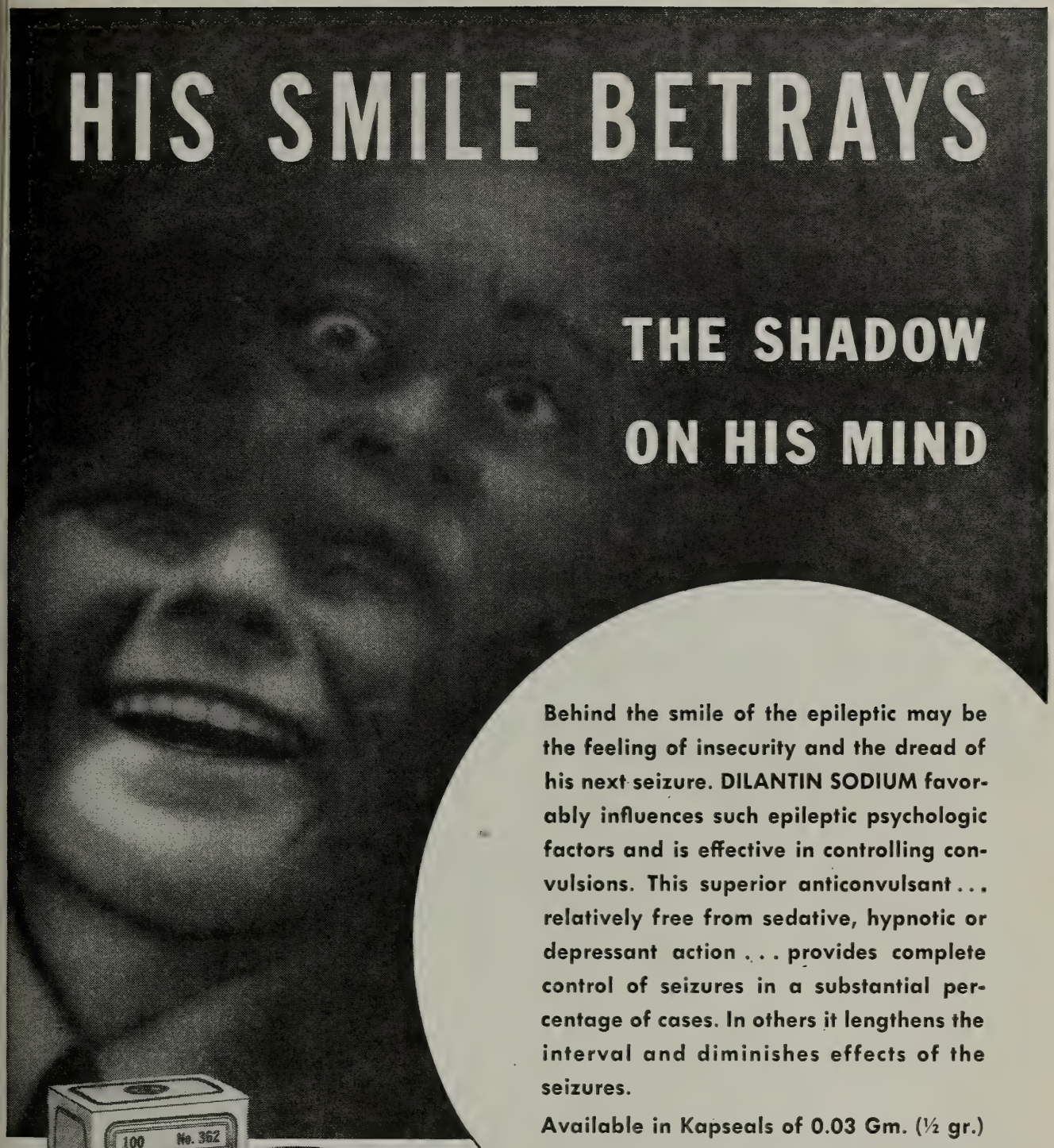
Allergy Fund Advisors Announced

The Board of Trustees of the American Allergy Fund, a national organization with headquarters in Cleveland, has announced the appointment of the following Scientific Advisory Council, through which all research projects will clear:

A. J. Carlson, M. D., Ph. D., LL. D., distinguished service professor emeritus of physiology, University of Chicago, chairman; Paul R. Cannon, M.D., chairman of the department of pathology, University of Chicago; Carl A. Dragstedt, M.D., chairman of the department of pharmacology, Northwestern University; Harry Goldblatt, M.D., associate director of the Institute of Pathology, Western Reserve University; and Sanford B. Hooker, M.D., professor of immunology, Boston University.

HIS SMILE BETRAYS

THE SHADOW ON HIS MIND



Behind the smile of the epileptic may be the feeling of insecurity and the dread of his next seizure. DILANTIN SODIUM favorably influences such epileptic psychologic factors and is effective in controlling convulsions. This superior anticonvulsant . . . relatively free from sedative, hypnotic or depressant action . . . provides complete control of seizures in a substantial percentage of cases. In others it lengthens the interval and diminishes effects of the seizures.

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American College of Radiology Issues Statement On Ownership and Use of Roentgenograms

A GENERAL statement of policy with regard to the ownership and use of roetgenograms was adopted by the Board of Chancellors of the American College of Radiology at the February meeting of that group.

Apparently the purpose of the statement is to clarify the situation in the face of frequent inquiries the College has received concerning ethical and legal problems involved in the respective rights of radiologists, patients, and referring clinicians in connection with roentgenograms.

TEXT OF STATEMENT

Following is the text of the report as it appeared in the monthly newsletter of the American College of Radiology for May, 1946:

"1. Roentgenograms should be used for the best interest of the patient.

"2. The roentgenograms are the legal property of the radiologist or of the hospital in which they were made. It is advisable, but not necessary, to mark on each film the statement, 'property of Dr. John Doe'. Such a mark is particularly desirable if the radiologist delivers the films to the referring physician instead of filing them in his office or hospital department.

"3. It should be the policy of the radiologist to make the films available for inspection by the physician who referred the patient for X-ray examination, along with a copy of the report of the radiologist. The best results are undoubtedly secured when it is possible for the radiologist and the referring physician to confer personally when the latter views the films.

"4. If the referring physician or the patient in behalf of the referring physician wishes to take the films away from the office or the hospital, it should be clearly understood that the films are 'loaned', and should be returned after the loan has served its purpose.

"5. If the patient dismisses the referring physician and goes to another physician, the films and the report should be made as freely available to the second as to the first physician who originally referred the patient. It is desirable that the patient notify the first physician of the change, and it may be assumed that he has done so, but even if this notification has not been made, the obligation of the radiologist is unchanged. When the second physician wishes to examine the films, it is assumed that he is doing so at the request of the patient.

"6. If the referring physician objects to the submission of the films to the second physician or to the giving to the latter a copy of the radiologist's report, the radiologist is obligated to do so in spite of this objection. If the referring physician has possession of the films and refuses to release them, the radiologist, whose legal property they are, has the right to take whatever action is necessary to get the films for the further benefit of the patient.

"7. All films should be legibly and permanently marked so that the patient can be identified and the date on which they were taken can be determined. This is important because, under such conditions, a comparison of films just made with others made previously may be the crucial factor necessary to establish a diagnosis or to estimate the progress or regression of a disease.

"8. When a medico-legal situation exists, the radiologist has a right to refuse to release the involved films if necessary for his own protection, except on a court order.

"9. A liberal attitude regarding the release of films is more desirable than strict insistence on one's legal rights. It is better to run the occasional risk of losing films than to endanger the enmity of a patient or of a physician by strict adherence to the rule, which in the past has led to attempts to make laws making the films legal property of the patient.

"10. In recognition of the universal importance of radiologic methods of examination, the principles regarding the use of roentgenograms outlined above are deemed by the American College of Radiology to be equally applicable to roentgenograms made by physicians other than specialists in radiology."

Dr. Saslaw Wins Borden Award

Samuel Saslaw, Ph.D., M.D., received the first annual Borden Undergraduate Research Award of $500 on the unanimous recommendation of the Research Committee of the Ohio State University College of Medicine.

The award, which was presented at the March convocation, is made annually to the graduating senior in medicine for that student research accomplishment which is deemed most meritorious. Dr. Saslaw's special field of investigation embraced the important problems of cellular and humoral immunity as they involve both viral and bacterial agents of infectious disease.

The significant role of synthetic folic acid in nutritional deficiency anemia and leucopenia, and thus in the maintenance of the natural resistance to infections, recognized and established only within recent months, stems partially from the fundamental studies in this University, in which Dr. Saslaw participated actively as an undergraduate medical student.



Truly, this is America

the village church...the white picket fence...the broad highways which lead to great cities . . . above all, the homes which breed good citizens.

AMERICA'S strength is bred in her homes. In thousands of towns and cities, where modest bungalow stands proudly alongside a local showplace, where the well-kept lawn of one merges with its neighbor...here, the roots of good citizenship are deeply planted.

Here, too, strong bodies and good minds are built.

Because it is so American to want the finest, they will get it. In medicine, for instance, American hospitals, American practitioners are the envy of the world. In quiet towns or teeming cities, the skilled hands of healing go about their work of keeping America well.

To the science of Medicine the physician brings his own individual art of healing, for just as no two people are exactly alike, so no two cases of illness are identical.

Thus, the physician must be free and unhampered, so that he may combine the *science* of Medicine, which is for humanity, with the *art* of healing, which is for the individual patient.

At Ciba, in a quiet community of broad streets and pleasant lawns, we produce many of the fine pharmaceuticals used by the medical profession. In modern laboratories, Ciba medical scientists pursue their search for yet newer aids to physicians in their treatment of disease. This, too, is the American way.

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Use of Streptomycin Limited to Research; Committee to Supervise Allocation

BECAUSE of the limited quantity of streptomycin, arrangements are now in affect to adjust the use of the present supply to a program of clinical investigation, according to an official statement appearing in the May 4 *Journal of the American Medical Association.*

Supervising this research will be the Committee on Chemotherapeutics and Other Agents of the National Research Council, at the request of the Civilian Production Administration and the Streptomycin Producers Advisory Committee.

DR. KEEFER IS CHAIRMAN

Chester S. Keefer, M.D., of Boston, chairman of this supervisory committee, and source of the official statement regarding the drug, announced that the primary interest of the committee in streptomycin is to determine its effectiveness and toxicity in certain infections which are not susceptible to treatment with sulfonamides, penicillin and other therapeutic agents.

According to the article much remains to be learned concerning limitations of the drug's usefulness, methods of administration, dosage, toxicity and other factors. Most of the information thus far obtained is from military and civilian hospitals as a result of clinicial investigations carried out under arrangements between producers of streptomycin and individual researchers.

STUDIES TO CONTINUE

Similar studies will be continued and amplified with streptomycin distributed by Dr. Keefer to those hospital physicians "most competent to obtain the vitally needed information".

Individual physicians having patients with diseases which are being studied by the committee have also been included in the research program. Full information concerning the bacteriologic diagnosis of the case is required, and when the drug is alloted, it is with the understanding that a full report of the case is to be returned to the committee for analysis, and that all unused material is to be returned.

Patients selected to receive streptomycin must be those whom it can be expected to benefit, and from whose treatment useful and needed information can be derived. Under present conditions many requests will inevitably have to be refused, the statement continued.

DISEASES TO BE STUDIED

The following named diseases are those which are under investigation: gram negative bacillary infections of the genito-urinary tract resistant to the sulfonamides; gram negative bacillary infections with bacteremia; Hemophilus influenzae infections, including meninigitis, pneumonia, middle ear disease, and laryngotracheitis; Friedländer's bacillus pneumonia; typhoid; Salmonella infections (paratyphoid); acute brucellosis with bacteremia; tularemia; bacterial endocarditis due to gram negative bacilli.

DISEASES NOT INCLUDED

Diseases not being investigated by the committee at present include: chronic idiopathic ulcerative colitis; lupus erythematosis acutus disseminatus; leukemia; cancer; fever of unknown cause; rheumatic fever; rheumatoid arthritis.

For the present time, only those cases of tuberculosis which were already under treatment prior to March 1, 1946 are being studied. A broader program is planned, but can not be instituted because of inadequate supplies of streptomycin.

All streptomycin now being produced must be reported to the Civilian Production Administration for allocation to the Army, Navy, U. S. Public Health Service, Veterans Administration, and to the National Research Council. After discussion of the needs of each, the supply is adjusted to current needs.

No one other than the above agencies may purchase the drug; no patient who receives it may pay for it; no physician is charged for it.

The article states that the program is being conducted "with the sole purpose of obtaining the necessary information concerning streptomycin in the shortest possible time.

COMMITTEE MEMBERS

Members of the supervisory committee in addition to the chairman are: John S. Lockwood, secretary, Yale University School of Medicine, New Haven; E. K. Marshall, Jr., Johns Hopkins University School of Medicine, Baltimore; Francis G. Blake, Yale University School of Medicine; Perrin H. Long, Johns Hopkins University School of Medicine; and W. Barry Wood, Jr., St. Louis.

Dr. Parke G. Smith, Cincinnati, has been appointed professor of surgery in the Urologic Division of the University of Cincinnati College of Medicine, and director of urology in the Department of Surgery, Cincinnati General Hospital. He succeeds Dr. Gordon F. McKim, whose resignation was accepted with regret by the Board of Directors of the University.

COSEASONAL TREATMENT OF HAY FEVER

Worthwhile relief can be obtained in a large percentage of pollinosis cases if hyposensitization treatment is begun on manifestation of symptoms.

Coseasonal treatment offers the added benefit of helping to establish the patient's tolerance to the specific pollen sensitivities. This aids in preparing the way for perennial treatment which, it is estimated, affords relief to 80 to 90 per cent of sufferers.

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Variations in Penicillin Potency Indicate New Standards In Use for Syphilis Treatment

THE fact that relative quantities of individual properties contained in commercial penicillin may vary from time to time has resulted in a new set of standards for the treatment of early syphilis, as announced in the May 25 *Journal of the American Medical Association.*

The suggested standards were submitted for publication by the Committee on Medical Research of the Office of Scientific Research and Development and the U. S. Public Health Service, after a joint study sponsored by the two groups.

The statement explains that commercial penicillin is not a single substance but a mixture of at least four, and possibly more, fractions of penicillin, which have been identified and named, in this country, penicillins G, X, F, and K.

QUANTITIES VARY

The relative quantities of each of the above fractions has varied to an unknown extent in the industry as a whole, as between different manufacturers, or even at different times from the same manufacturer, according to the report.

Research has shown that pencillin K is relatively ineffective in syphilis treatment, "apparently due to the fact that, unlike penicillins G, X, and F, it is rapidly destroyed in the body".

RESULTS LESS SATISFACTORY

The committee reported that in this connection the results of penicillin treatment of early syphilis have been less satisfactory since May, 1944 than prior to that date, when the proportion of impurities was higher, and the amount of penicillin K lower.

Investigations have revealed that penicillin that was originally available had an approximate potency of 200 units per milligram, which has gradually been increased by elimination of impurities to the present level of 900 to 1400 units per milligram. However, it has been noted that a 15-day treatment with 2,400,000 units of this penicillin gives less satisfactory results than the previous treatment with 1,200,000 units in seven and one-half days.

NEW STANDARDS SUGGESTED

The article concludes with the following recommendations to the medical profession with regard to treatment of syphilis:

Around-the-clock injections should be given into the muscles every two to three hours for a minimum of seven and one-half days.

Patients with primary syphilis should receive not less than 3,600,000 units of penicillin while those with early secondary syphilis should receive not less than 5,400,000 units.

In case of relapse the patient should receive injections of mapharsen, arsenic or bismuth in addition to penicillin.

Under no circumstances should penicillin in its present available form be admnistered by mouth for the treatment of syphilis.

In treating neurosyphilis, penicillin can be advantageously combined with fever therapy.

The report further states that the problem is receiving "intensive study in a number of cooperating institutions. The penicillin manufacturers are likewise aware of the situation, are cooperating in the study, and are taking practical steps in production to correct the identifiable difficulties."

Congress of Physical Medicine

The American Congress of Physical Medicine will hold its twenty-fourth annual scientific and clinical session September 4, 5, 6, and 7, inclusive, at the Hotel Pennsylvania in New York. Scientific and clinical sessions will be given each day. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction courses will be held September 4, 5, and 6. For information concerning the convention and the instruction course, address the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

According to the Forty-fourth Annual Presentation of Licensure Statistics by The Council on Medical Education and Hospitals of the American Medical Association, published in the May 11 issue of the J.A.M.A., the Ohio State Medical Board during 1945 issued 325 licenses to practice medicine and surgery, following examination, and 127 through reciprocity with other states. During the same year, the state of California issued 500 licenses following examination and 708 through reciprocity.

* * *

George Larson, director, Midwest Field Army, American Cancer Society, with headquarters in Chicago, has been named executive director of the Pennsylvania division of the cancer society. Until joining the American Cancer Society several years ago, Mr. Larson was assistant secretary of the State Medical Society of Wisconsin.

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Commission on Hospital Care Publishes Article on Public Health Medical Center Concepts

IN the *Hospital Survey News Letter* for April, 1946, the Commission on Hospital Care, located in Chicago, published an article entitled "Health Center Concept", regarding public health and medical service centers.

In this article, the commission stated that the establishment of such centers during recent years in outlying areas has provided a mechanism whereby some of the difficulties surrounding adequate rural medical service may be surmounted.

According to the report, it would be the purpose of units of this sort to make available some of the functions normally provided by the public health agency and the hospitals.

AS AN EDUCATIONAL CENTER

Among the services of such an institution, according to the statement of the commission, would be the provision of a focal point about which public and voluntary agencies could coordinate their efforts in general health education activities.

It was proposed that the centers serve as headquarters for the official public health agency with offices for the health officer, sanitarian, and public health nurses, and as a base for programs in sanitation; preventive medicine, such as immunization against preventable diseases and early diagnosis of tuberculosis; control and treatment of venereal diseases, maternal and infant care activities, and other projects.

EQUIPMENT PROVIDED

It was suggested that in order to attract competent physicians to the area, the center should contain equipment essential to the practice of modern medicine; not as complete as the large hospital, but at least provisions for routine tests and X-ray services.

The commission recommended that in the smallest of the centers an office be provided for the physician who might be available at appointed hours or upon call; in others, office facilities for the one or more physician residents of the community. Still another suggestion was that the physicians located in the community might conduct independent offices but utilize the center's diagnostic and other facilities.

MATERNAL AND INFANT CARE

The report continued, "The provision of a few beds and proper sterilization and delivery room facilities in the public health and medical service center for the care of normal obstetrical cases would be highly desirable. Prenatal examination and attention for the expectant mother as well as postnatal service to mother and infant could also be readily provided."

Not directly concerned with raising the level of public health, but of real importance is the provision of adequate facilities for emergency care in accident and other unusual cases, the commission said. Especially in localities which have neither medical nor hospital service within a radius of a number of miles, some effort to provide temporary facilities until suitable arrangements can be completed for transfer of the patient to a general hospital was advised.

AFFILIATION WITH HOSPITALS

The article asked for a definite working arrangement for affiliation between centers and conveniently located general hospitals with regional ambulance service for the transportation of patients from centers to hospitals.

Urged was the administration of the center by the hospital's organized medical staff, and the ready access for the local physician to the advice and consultation of the hospital's qualified specialists.

It was also urged that the local physician be privileged to follow those of his patients who might need services that are available only at the general hospital, and that general hospitals and medical teaching centers "provide opportunities" whereby the local physicians can continue their professional training and keep informed concerning the latest developments in medical science.

CONTROL OF PUBLIC HEALTH AGENCY

The report continued with the following statement:

"In addition to its affiliation with a nearby general hospital, the public health activities of the center should be integrated with and under the control of the district or state public health agency. Many existing units today find it very difficult to function effectively without some participation and supervision from some such public health agencies. A degree of this kind of control is a desirable supplement to that exercised through voluntary affiliation and is a natural tendency in that some operating funds are usually provided from a governmental source."

In a discussion of the advisability of the medical service center for small communities as against the small hospital the commission declared that considerable thought and study should be given before a decision is made to erect any

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new hospital, particularly one of less than 50 beds capacity.

MEDICAL CENTERS VS. SMALL HOSPITALS

"Experience has shown", said the article, "that small hospitals are not economical to operate. The initial cost of construction is overshadowed by the continuous operating expense. Also, small hospitals frequently cannot sustain the large expenditures necessary to replace equipment made obsolete by the rapid advances in medical science.

"Every hospital, regardless of size, must retain sufficient staff and personnel to permit it to function effectively. Certain key positions must be manned irrespective of the size of the institution. In small hospitals, one person may be able to fill more than one assignment, but the per patient cost to maintain these positions is much higher when the average daily census is less than 50, than it is in an institution caring for two, three, or four times that number."

Recent Rulings of Attorney General of Interest to Physicians

Among opinions recently issued by Attorney General Hugh S. Jenkins are several of interest to the medical profession. The syllabi follow:

No. 750—The appropriation contained in House Bill 477 passed by the 96th General Assembly for the erection of a new hospital building for Columbus State Hospital, may be used for the construction of a receiving hospital for the observation, care and treatment of the mentally ill on grounds of the Ohio State University, under a proper agreement with the trustees of such university, preserving to the department of public welfare the control and management of such hospital; and pursuant to such agreement said hospital may be used in cooperation with the college of medicine of said university and the medical center authorized and provided in said House Bill 477.

No. 899—(1) The mayor of a city, the health district of which has been consolidated with a general health district, the affairs of which combined district are being administered by the board of health of the original city district, may appoint as members of such combined district persons who are not residents of the city. (2) Under the provisions of Sec. 4404 G. C., the appointment of members of a board of health of a combined general health district, the affairs of which are being administered by the board of health of a city health district, must be confirmed by the council of the city which forms a part of such combined health district.

No. 975—(1) Sec. 1261-26, G. C., places upon boards of health the mandatory duty to provide for the prompt diagnosis and control of communicable diseases. Under that authority the board of health of a general health district is charged with the care and supervision of tuberculous patients. (2) Where the board of county commissioners of a county which does not operate a county tuberculosis hospital and which is not part of a district in which tuberculosis clinics are maintained, has assumed the care and supervision of tuberculosis patients by employment of public health nurses, no formal agreement is necessary to relinquish such care and supervision to the board of health of the general health district of such county, nor is it necessary to first obtain the consent of such board of health.

Ohio Health Officials Hold Annual Session in Columbus, June 14

The annual meeting of the Ohio Federation of Public Health Officials was held at the Deshler-Wallick Hotel, Columbus, June 14. The following addresses were made at the morning session: "The Ohio River Valley Water Sanitation Compact", by B. V. DeVier, assistant engineer, Ohio Department of Health; "Mental Illnesses, A Public Health Problem", Dr. Attilio Laguardia, assistant commissioner of the Division of Mental Hygiene, Ohio Department of Welfare; "Recent Information on Communicable Disease Control", and "Activities of the Ohio Department of Health in Aiding Local Health Departments", Dr. P. L. Harris, chief of the Division of Communicable Disease, Ohio Department of Health.

At the conclusion of the talk given by Mr. Nelson on "A Health Program for Ohio", referred to in the accompanying article, the Federation by a unanimous vote adopted a resolution commending the Ohio State Medical Association on its 25-point program and offering the assistance of the organization in furthering the activities suggested.

Following the morning program, Dr. R. W. DeCrow, Wilmington, health commissioner of Clinton County and president of the federation introduced his successor, Dr. Walter H. Hartung, who is health commissioner of Toledo.

At the luncheon program, which began at 12:30 P. M., Dr. Roger E. Heering, Director, Ohio Department of Health, and Dr. Carl A. Wilzbach, Cincinnati, chairman of The Joint Committee on Tuberculosis in Ohio, addressed the group, and Charles S. Nelson, Executive Secretary of the Ohio State Medical Association spoke on "A Constructive Health Program for Ohio". Mr. Nelson outlined the State Association's 25-point health program for Ohio as adopted by the House of Delegates at the Annual Meeting in May.



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Fewer Local Health Units In Ohio With Larger Budgets, Recommended by Special A.P.H.A. Committee

REALLOCATION of jurisdictional health units and increased expenditures for health services were chief among the recommendations for Ohio in a report entitled *Local Health Units for the Nation*, by Haven Emerson, M.D., chairman of the Subcommittee on Local Health Units, American Public Health Association.

The Ohio Public Health Law, dating back to 1919, allows a local health department for each county and for each city. Ohio at present has 203 local health departments. The law further permits the union of city and county health districts, union of two county health districts, and provides that a city may contract with another to provide its health service.

In lieu of the present system, with so many local health units, with 58 non-medical health officers, and 110 units with part-time officers, the committee therefore recommends only 53 health jurisdiction units with about two counties per unit. Twenty-one would include only one county, 29 would be bi-county, and three would have three counties.

Average population of the 53 units would be 130,000; least populous, 40,500 inhabitants; most populous, 1,217,300. Ten units would be below 50,000 and fifteen above 100,000.

ADDITIONAL COSTS ESTIMATED

Estimated cost of administering this system is $6,638,800, or a per capita of about 96 cents. In this figure, about 20 per cent is included for costs other than salaries. This estimate is in contrast with the 1942 expenditure of $4,009,100, a per capita of 58 cents. About 18 per cent covered costs other than salaries.

The committee justifies this 50 per cent increase in expenditures by the fact that while in 1942 a third of the state population was served through part-time health officers, the new plan would provide for a full-time medical health officer attached to each unit, and for 28 additional full-time medical administrative positions in nine units.

Commenting on the recommendation for a larger health budget in Ohio the report stated: "Ohio, as tenth among all the states in spendable income, can surely absorb the cost of basic minimum local health service from its own sources of public revenue".

MORE PERSONNEL SUGGESTED

The service of 268 part-time clinicians, with at least two assigned to each unit, also is recommended.

A proposed public health nursing program designed to serve the needs of the entire population, including school health work, but without bedside care of the sick, would require 1,383 nurses, according to the report.

In the field of environmental sanitation, 66 engineers, 38 veterinarians, and 206 sanitarians of non-professional grade are recommended.

A total of 464 clerical workers is suggested, 27 of whom would be statistical clerks. Laboratory service is proposed for each unit, but on a very modest basis for the least populous. Total laboratory personnel would include 24 professional, 119 technical and 119 unskilled. It is assumed that the State Laboratory would supervise and assist the local units.

Thirty-six health educators are proposed, 12 of whom would be shared by two smaller adjacent units.

HOW UNITS WOULD BE FORMED

Under the committee's proposal for 53 health units in Ohio, the 88 counties would be organized into units as follows: Unit 1, Fulton and Williams; Unit 2, Lucas; Unit 3, Defiance and Henry; Unit 4, Wood; Unit 5, Ottawa and Sandusky; Unit 6, Seneca.

Unit 7, Erie and Huron; Unit 8, Lorain and Medina; Unit 9, Cuyahoga; Unit 10, Geauga and Lake; Unit 11, Ashtabula; Unit 12, Trumbull.

Unit 13, Portage; Unit 14, Mahoning; Unit 15, Carroll and Columbiana; Unit 16, Summit; Unit 17, Stark; Unit 18, Ashland and Wayne.

Unit 19, Richland; Unit 20, Crawford and Wyandot; Unit 21, Hancock and Hardin; Unit 22, Paulding and Putnam; Unit 23, Mercer and Van Wert; Unit 24, Allen.

Unit 25, Auglaize and Shelby; Unit 26, Darke and Preble; Unit 27, Miami; Unit 28, Champaign and Logan; Unit 29, Delaware and Union; Unit 30, Marion and Morrow.

Unit 31, Knox and Licking; Unit 32, Coshocton and Holmes; Unit 33, Tuscarawas; Unit 34, Harrison and Jefferson; Unit 35, Belmont and Monroe; Unit 36, Guernsey and Noble.

Unit 37, Muskingum; Unit 38, Franklin; Unit 39, Madison and Pickaway; Unit 40, Clark; Unit 41, Montgomery; Unit 42, Fairfield, Hocking, and Perry.

Unit 43, Morgan and Washington; Unit 44, Athens, Meigs, and Vinton; Unit 45, Fayette and Ross; Unit 46, Clinton, Greene, and Warren; Unit 47, Butler; Unit 48, Hamilton.

Unit 49, Brown and Clermont; Unit 50, Adams and Highland; Unit 51, Jackson and Pike; Unit 52, Scioto, and Unit 53, Gallia and Lawrence.

Detailed information concerning suggested personnel and annual budgets for each area has been tabulated. A copy of the report may be obtained for $1.25 by writing to the Commonwealth Fund, 41 East 57th Street, New York 22, N. Y. The report was made possible by a grant of the Commonwealth Fund, which also financed its publication. The staff of the Fund also contributed to the final editing.

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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32, 241; N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.*

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Do You Know - - -

Dr. Harold C. Lueth, Evanston, Ill., has been appointed Dean of the University of Nebraska College of Medicine, Omaha, effective July 1. Formerly associate professor of medicine at the University of Illinois College of Medicine, Dr. Lueth recently was separated from service in the Army Medical Corps, with the rank of colonel. His five-year tour of duty included assignments as chief of medical service at the Station Hospital, Fort Sheridan, Ill., and liaison officer to the American Medical Association for the Surgeon General.

* * *

The Pan-American Medical Women's Alliance, Inc., was incorporated at Columbus, April 18, "to set up an organization for the interchange of ideas among women physicians in the Western Hemisphere". The plan was fostered in Cincinnati, and according to press notices, the charter was applied for from Cincinnati because the *Medical Woman's Journal* is published there. Scientific papers, both in English and Spanish, would be prepared in Cincinnati by the new organization. The first meeting will be held in Mexico City in about six months.

* * *

At the recent annual meeting of the Ohio State Nurses Association, a resolution was adopted urging defeat of the Wagner-Murray-Dingell bill, asserting "it would place American medicine under the regimentation of a Federal bureaucracy", and would result "in the deterioration of medical services in this country".

* * *

Dr. Arthur M. Culler, associate professor of ophthalmology at the Ohio State University was one of 16 medical specialists named to the Reserve Consultants Board of the Naval Bureau of Medicine and Surgery. The board will assist the bureau in furthering the graduate training program for naval medical officers.

* * *

During the meeting of the American Association for the Study of Goiter, in Chicago, June 20, 21, and 22, Dr. E. Perry McCullagh of Cleveland presented a paper on "Comparative Effects of Pituitary Irradiation Therapy and Electrocautery to the Pituitary in Cases of Severe Exopthalmos of Graves Disease". Dr. I. Darin Puppel, Columbus, spoke on "The Surgical Significance of the Functioning Activity of the Nodular and Paranodular Tissues of Nodular Goiter".

* * *

Dr. Harry Goldblatt, professor of experimental pathology at the Western Reserve School of Medicine, has accepted a new position as director of the Institute for Medical Research at the Cedars of Lebannon Hospital, Los Angeles.

* * *

The Distinguished Service Award of the Academy of Medicine of Cleveland has been presented to Dr. Jacob E. Tuckerman in recognition of his long and faithful service to organized medicine and the community.

* * *

Dr. Tom D. Spies, associate professor of medicine, University of Cincinnati College of Medicine, is one of a group of scientists chosen to spend six to eight weeks lecturing and visiting in Switzerland this year. The trip is sponsored by the American Swiss Foundation for Scientific Exchange, Inc., Montclair, N. J., a newly-organized group interested in restoring contact between the United States and Switzerland, in medicine and the natural sciences. The foundation also will bring outstanding Swiss scientists to this country.

* * *

New officers of the Ohio State Eclectic Medical Association are: Dr. C. G. Smith, Marion, president; Dr. G. W. DeMuth, Sherwood, vice-president; Dr. J. S. Hull, Hicksville, secretary; and Dr. F. L. Thomas, Marion, treasurer.

* * *

The William S. Knudsen Award for the most significant contribution in the field of industrial medicine in the current year was presented recently to Col. Anthony J. Lanza, associate medical director of the Metropolitan Life Insurance Company, New York.

* * *

Dr. Harold R. Hennessy, formerly a lieutenant colonel in the Army Medical Corps, has been appointed assistant secretary of the Council on Industrial Health of the American Medical Association. Dr. Hennessy was overseas for two years



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and for a considerable period of his Army service, was Industrial Medical Officer of the Ninth Service Command, Ft. Douglas, Utah. Prior to going into the Army, he was associated with the California State Health Department.

* * *

Rhode Island is the first state to enroll 50 per cent of its entire population in the Blue Cross hospitalization plan.

* * *

First units of the $100,000,000 medical center at Houston, Texas, are now under construction. Participating in the project are four universities: Baylor University, University of Texas, University of Houston, and Rice Institute; also 12 or more hospitals and several research institutions.

* * *

A grant of $1,000 has been made to the University of Cincinnati College of Medicine by Winthrop Chemical Company, Inc. The purpose of the grant is to support investigations on nutrition carried out during 1946 under the direction of Dr. Tom D. Spies.

* * *

The Schering Award for 1946, a competition open to undergraduate medical students, has recently been announced. Held annually to encourage medical students to acquire further knowledge of various fields of endocrinology, the subject of this year's thousand dollar prize contest will be, "The Role of Hormones in Sterility".

* * *

Children's Hospital of Cincinnati, and its research foundation have been granted $10,000 from the Nutrition Foundation, New York, for experimental research on diabetes, especally among children. Dr. George Guest, associate professor of pediatrics at the University of Cincinnati College of Medicine, is director of the children's clinic of the hospital which has been engaged in long-term studies of diabetic children.

* * *

The Ohio Public Health Association, Columbus, has donated $5,000 for research in the field of tuberculosis control, according to Dr. Charles A. Doan, vice-president of the association. The funds will be used to supplement grants of the National Tuberculosis Association for research work.

* * *

Dr. H. Campbell Haynie, Nashville, Tennessee, has been named assistant medical director of the University Hospital, Columbus, and its outpatient department, and assistant professor of medicine in the Ohio State University College of Medicine. Prior to service with the Army, Dr. Haynie was resident physician at the University Hospital.



Survey of Health Facilities Available for Ohio Children Started Under Direction of Academy of Pediatrics

LATE this Summer the physicians of Ohio will receive from the Ohio Study of Child Health Services of the American Academy of Pediatrics, a questionnaire which will serve as the basis of information concerning available health facilities for the children of the state.

The study is part of a nation-wide project sponsored by the American Academy of Pediatrics with the assistance of the U. S. Public Health Service and the Children's Bureau. The Academy wishes it understood, however, that this is not a government project, as the director, with headquarters in Washington, is paid by and answerable to the Academy, and the personnel who are on loan from the government are under his direction.

DOCTORS TO BE POLLED

The questionnaire is to determine what facilities and services are available for children and what care they are now receiving. Each physician will be asked to what degree he carries the load of medical care of the young patients of his community, and if the health facilities in the community have met his medical requirements in caring for these patients.

At the close of the national survey, the material will be presented in a factual report and at that time the Academy of Pediatrics, the U. S. Public Health Service, and the Children's Bureau, either together or separately may wish to undertake an interpretation of the facts in order to develop recommendations for medical care programs.

DATA WILL BE VALUABLE

It is expected that data will be provided upon which physicians may base their stand in matters of planning health programs for Ohio's youth, for, as the Academy puts it, "The several bills now before Congress indicate clearly that if the physicians do not assume this responsibility, plans for medical care will be made by others".

Dr. Benjamin Hoyer, Cincinnati, is chairman of the Ohio Study of Child Health Services of the American Academy of Pediatrics, and Dr. E. V. Turner is executive secretary. Dr. Turner is a native of Belmont County and a graduate of Harvard University Medical School. His office is located at Children's' Hospital, Columbus.

The survey has the approval of The Council of the Ohio State Medical Association.

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Activities of County Societies

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

ADAMS

Members of the Adams County Medical Society held an outing at Serpent Mound State Park, June 19. During the morning session, Dr. William Compton of Cincinnati presented a paper on treatment of burns. After dinner, Dr. Samuel Meltzer of Portsmouth spoke on "Ossification of Soft Tissues with Paraplegias". — Hazel L. Sproull, M. D., secy.

BUTLER

Members of the Butler County Medical Society at a meeting May 14, pledged $25,000 to institute a campaign to raise $200,000 towards the erection of a $400,000 nursing school and residence at Mercy Hospital, Hamilton.—News clipping.

CLINTON

Dr. Robert Conard, Wilmington, reported on the Centennial Meeting of the Ohio State Medical Association at the May 14 meeting of the Clinton County Medical Society in Wilmington. Dr. Kelley Hale, also of Wilmington, reported on the surgical section held in connection with the meeting.

Dr. R. R. Buchanan of Wilmington spoke during the June 4 meeting of the society in Wilmington. His subject was "Medical Service in an Armored Force Division".—R. W. DeCrow, M. D., secy.

HAMILTON

An outing was held June 25 by the Academy of Medicine of Cincinnati in honor of physicians returning from war service. Golf in the afternoon was followed by a dinner.

The next regularly scheduled meeting of the Academy will be September 17, at which time new officers will be installed.—Bulletin.

WARREN

Dr. Walter Roehll of Middletown addressed the May 14 meeting of the Warren County Medical Society on the subject "Psychosomatic Medicine".—News Clipping.

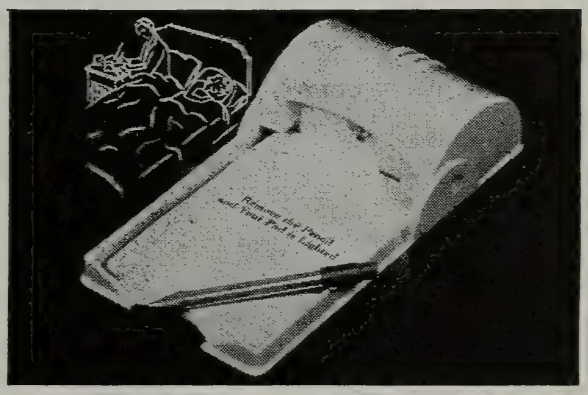
Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

CLARK

Dr. George Thomas, of the University of Pittsburgh School of Medicine, spoke at the May 20 meeting of the Clark County Medical Society at Springfield City Hospital. Dr. Thomas is chief

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anesthetist on the staff of the University Group Hospitals and St. Francis Hospital in Pittsburgh. —News Clipping.

DARKE

The Darke County Medical Society held its regular meeting at the Wayne Hospital in Greenville, May 21. The speaker was Dr. Marion Coleman of Dayton, who talked on "Cystitis in the Female". This next meeting of the society will be held in September.—W. D. Bishop, M.D., secy.

MIAMI

A special meeting of the Miami County Medical Society was held at the Stouder Memorial Hospital, Troy, on June 7 for the purpose of reviewing the matter of establishing a policy for the recommended procedure of diagnosis of tuberculosis in Miami County, and to suggest the opinion of the Society with regard to the work of the Miami County Tuberculosis Association.—G. A. Woodhouse, M.D., secy.

MONTGOMERY

The Montgomery County Medical Society began with the month of June, the publication of its official bulletin, *The Montgomery County Medical News.* Dr. Reid P. Joyce of Dayton is the editor, and associate editors are Dr. Lynn Baker, Dr. Richard Hochwalt, and Dr. Clarence Derby. Business manager is Mr. Frank C. Bateman.

The June 5 meeting of the Society was held at the Dayton Country Club. Dinner speaker was Dr. Robert Zollinger, professor of surgery, Ohio State University College of Medicine, who discussed "Management of Gastric Lesions".

The General Practice Section of the Montgomery County Medical Society was organized January 6, 1946, for the purpose of furthering the general welfare of physicians engaged in the general practice of medicine in that county. Meetings are held the last Wednesday evening of every month. Officers are: Dr. J. K. Bailey, chairman; Dr. Paul Troup, vice-chairman; Dr. J. H. Loeb, treasurer; and Dr. A. P. McDonald, secretary. The section met with the directors of the local social agencies in May.—Bulletin.

Third District

(COUNCILOR: J. CRAIG BOWMAN, M.D., UPPER SANDUSKY)

ALLEN

Dr. Wynne M. Silbernagel of Columbus addressed the May 21 meeting of the Allen County Academy of Medicine on the subject "New Concepts in the Management of Common Obstetrical Complications". The meeting was held at the Memorial Hospital in Lima.—News Clipping.

MARION

In a combined meeting of the City Hospital staff, city officials and the Marion County Academy of Medicine, held June 4 at the hos-

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pital in Marion, the shortage of nurses was discussed and plans were made to alleviate the situation.—News Clipping.

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

ASHTABULA

Dr. John A. Toomey of Cleveland addressed the Ashtabula County Medical Society at its dinner meeting at the Hotel Ashtabula, May 14. His subject was "Laryngeal Emergencies in Infants and Children". The society voted to approve the organization of a Woman's Auxiliary. —News Clipping.

CUYAHOGA

At the annual meeting of the Board of Directors of the Academy of Medicine of Cleveland on May 24, Dr. Russell B. Crawford, superintendent of Lakewood Hospital was elected president of the Academy for 1946-47. Dr. David M. Keating, Cleveland, was elected vice-president, and Dr. Robert F. Parker of Cleveland was reappointed secretary-treasurer.

Dr. Crawford has just finished a year as vice-president, and chairman of the Academy's executive committee. He has been superintendent of Lakewood Hospital since 1940, a position to which he went direct from private practice. Dr. Keating, during the past year, has served as chairman of the Academy's committee on public policy and legislation.

The Industrial and Orthopedic Section of the Academy met at St. Luke's Hospital June 12 to hear a paper on "Rehabilitation of the Amputee", by Dr. Henry H. Kessler, former captain in the U. S. Navy Medical Corps.—Bulletin.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M.D., AKRON)

MAHONING

At the May 21 meeting of the Mahoning County Medical Society, held at the Youngstown Club in Youngstown, Dr. Elmer L. DeGowin of the University of Iowa presented a paper on "Anuria, Differential, Diagnosis and Treatment".

Dr. George T. Pack, professor of clinical surgery at the New York Medical College, spoke on "The Extension of Radical Surgery in the Treatment of Cancer" during the June 18 meeting of the society at the Youngstown Club.—Bulletin.

STARK

Dr. J. W. Shirer, department of surgery, University of Pittsburgh School of Medicine, spoke on "Surgical Treatment of High Blood Pressure" at the May 22 meeting of the Stark County Medical Society, held at the Alliance Country Club, Alliance. Dr. William Skipp, Youngstown, paid tribute to Dr. R. L. Rutledge, Alliance, with regard to his election as president-elect of the

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Ohio State Medical Association. Dr. Carl Lincke, Carrollton, Seventh District Councilor, was an honored guest.—News Clipping.

Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

HOCKING

Dr. Robert Daly of Columbus spoke on "Common Obstetrical Emergencies" at the June meeting of the Hocking County Medical Society in Logan.—Owen F. Yaw, M.D., secy.

Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

LORAIN

Dr. Delbert Russell, Lorain, spoke on "Roentgenotherapy" at the June 11 meeting of the Lorain County Medical Society, held at Castle-on-the-Lake, Lorain.—L. H. Trufant, M.D., secy.

WOMAN'S AUXILIARY NEWS

BY MRS. FRED W. BROSIUS, MIDDLETOWN
Chairman, Publicity Committee

ASHTABULA

Mrs. Paul A. Davis, Akron, President of the Woman's Auxiliary to the Ohio State Medical Association, and Mrs. A. M. Mills, Ashtabula, Director of the Fifth District, assisted with the recent organization meeting of Ashtabula County Auxiliary. Mrs. Davis gave an interesting talk on "The History of the Woman's Auxiliary and Its Place in the Community".

Twenty-two physicians' wives attended this initial meeting; all paid dues and subscribed to the *Bulletin.*

Officers elected were as follows: Mrs. A. M. Mills, Ashtabula, president; Mrs. N. F. Crandall, Ashtabula, pres.-elect; Mrs. J. F. Docherty, Conneaut, vice-president; Mrs. W. H. Eberle, Ashtabula, secretary; and Mrs. P. R. Longaker, Conneaut, treasurer.

BUTLER

The final meeting of the Woman's Auxiliary to the Butler County Medical Society was held May 24 at the residence of Mrs. Clyde Stafford, Oxford.

Annual reports were given during the business session by the following committee chairmen: Mrs. Ross Hill, program; Mrs. C. T. Atkinson, public relations; Mrs. W. H. Williams, legislative; Mrs. W. H. Roehll, ways and means; Mrs. H. J. Baker, and Mrs. D. F. Gerber, *Hygeia* and *Bulletin;* Mrs. J. A. Mackie, membership Mrs. Harry Burdsall, publicity.

Mrs. W. H. Williams, past-president, installed these new officers: Mrs. Ross Hill, president-elect; Mrs. Azel Ames, vice-president; Mrs.



E. T. Keating, recording secretary; Mrs. W. F. Vinnedge, corresponding secretary; Mrs. E. T. Storer, treasurer; and Mrs. Kenneth Smith, director.

Mrs. Fred Brosius, retiring president, presented the gavel to Mrs. C. J. Chamberlin, president for the ensuing year.

Following the business meeting a musicale was given by Mrs. Gertrude Alexander, vocalist, accompanied by Mrs. H. A. Moore, of Oxford. Max Carr, a young piano student at Miami University, presented several selections.

CLINTON

A Woman's Auxiliary to the Clinton County Medical Society was organized May 14; a constitution and by-laws were adopted; and the following officers were elected: Mrs. Kelley Hale, president; Mrs. L. H. Fullerton, pres.-elect; Mrs. E. Dalton Peelle, vice-president; Mrs. C. E. Kinzel, secretary; Mrs. J. H. Frame, treasurer; Mrs. William L. Wead, corresponding secretary; Mrs. W. L. Regan, parliamentarian.

CUYAHOGA

The Woman's Auxiliary to the Cleveland Academy of Medicine held a tea May 23 at the Westwood Country Club, Cleveland. Mrs. Norma Harrison Thrower, dramatic artist, was presented, and Mrs. Marie Simmelink Kraft, contralto, sang. Mrs. S. C. Lind was general chairman of the affair; Mrs. Abram Bruner, hospitality chairman. Program committee included Mrs. F. C. Oldenburg, Mrs. George Crile, Jr., and Mrs. William R. Barney. Mrs. F. T. Gallagher is president.

HIGHLAND

The Highland County Medical Society and the Woman's Auxiliary enjoyed a six o'clock dinner at Penn's Restaurant in Hillsboro, June 5. It was in honor of Dr. J. C. Larkin, who recently completed fifty years of medical practice in Highland county. A beautiful bowl of flowers was presented to Dr. Larkin, who recounted the many changes in medical treatment during fifty years.

The dinner was also in honor of the wives of the physicians who have returned from service. After a brief business session, both groups were entertained by Dr. Albert Borreson of Greenfield, recently returned from the South Pacific. An interesting collection of Japanese weapons and unusual shell necklaces and bracelets were on display.

"Due to the extreme heat," Dr. Borreson related, "only two out of ten native babies survive to be one year old." He also emphasized the many hardships and suffering endured so bravely by "our boys" over there.

LUCAS

A delightful tea was enjoyed by the members of the Woman's Auxiliary to the Academy of Medicine of Toledo and Lucas County in April

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at the home of Mrs. Murray Goodrich, Toledo. Mrs. Norman Muhme and Mrs. Richard Hotz of Toledo served as assisting hostesses.

Mrs. W. Frank Maxwell of Toledo had an interesting and admiring audience when she staged a one-woman art show of her canvases during the afternoon. Mrs. Frank McNierney, Toledo, is president of the auxiliary.

MARION

The regular meeting of the Woman's Auxiliary to the Marion County Academy of Medicine was held April 27 at Hotel Harding, Marion. Following luncheon a brief business meeting was conducted by Mrs. John A. Dodd, president. Mrs. Clare W. Smith, Marion, and Mrs. Dodd were chosen to attend the State Auxiliary in Columbus as delegates. Dr. A. E. Morrison, Marion, guest speaker, discussed "Cancer and X-ray". He said, "One out of eight persons die of cancer and all persons, especially women over 40 years of age, should have an examination every six months". He pointed out that cancer spreads in three ways, by direct growth, through the lymph system to distant parts, and through the blood stream.

Mrs. Charles W. Sawyer or Marion will entertain the auxiliary in May. Mrs. Harry J. Merchant was hostess for the April meeting. Reported by Mrs. Clarence Weber, publicity chairman.

ROSS

Mrs. H. M. Crumley, Chillicothe, was elected president of the Woman's Auxiliary to the Ross County Academy of Medicine, when the group assembled May 2, at the home of Mrs. Loy Hoyt in Chillicothe. Others elected were: Mrs. John Franklin, Chillicothe, vice-president; Mrs. W. B. Smith, Frankfort, treasurer; and Mrs. F. W. Nusbaum, Chillicothe, secretary. A book review of "The Egg and I" was given by Mrs. George Hammond. Delegates chosen for the State Auxiliary meeting were Mrs. Crumley and Mrs. E. H. Artman of Chillicothe.

Preceding the meeting a covered dish dinner was served to 16 members and three guests.

SCIOTO

Installation of officers for the coming year featured the May meeting of the Woman's Auxiliary to the Hempstead Academy of Medicine at the Hurth Hotel in Portsmouth. Luncheon covers were laid for thirty members. At the business session reports were made on the state convention in Columbus and a summary of the activities of the various standing committees was made by the chairmen. Mrs. S. L. Meltzer conducted the installation of the following officers: Mrs. W. C. McCann, president; Mrs. L. B. Hatch, vice-president; Mrs. Milton Levine, president-elect; Mrs. George Blume, secretary; Mrs. George Martin, treasurer; and Mrs. Clyde Everett and Mrs. Harry Rapp, board members.

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Dr. Heering Issues Clarifying Statement on Scarlet Fever Control Regulations

In order to clarify the interpretation of the new scarlet fever control regulations adopted a year ago by the Public Health Council, Dr. Roger E. Heering, Director of the Ohio Department of Health, issued the following communication to the health commissioners of the state on June 13, which communication also will be of interest to physicians:

"Owing to the fact that there seems to be considerable confusion relative to the change in Regulation 16-35, for the control of scarlet fever, adopted by the Public Health Council, June 24, 1945, this letter is an attempt to clarify the situation.

"Under the old regulation, it was required that a scarlet fever case could not be released from isolation in less than twenty-one days from the onset of the disease. The new regulation provides that the period of isolation is to be determined on the basis of the clinical course of the infection. In other words, when the patient is clinically well, isolation may be terminated at the time it is determined that the patient is clinically recovered. A comment has been included under Paragraph '2' of the new regulation stating, 'In uncomplicated cases the period of communicability should be completed within 14 days.' This is merely a comment, and is not to be interpreted as meaning that isolation should be extended to or limited to a period of 14 days. Local boards of health, by regulation, can establish any period of isolation considered desirable.

"It should be kept in mind that isolation refers to the patient and that quarantine refers to the contacts.

"Quarantine, under Paragraph '5' of the new regulation, refers to the legal provision for quarantine. The reference is Section 4429 of the General Code which names scarlet fever as one of the quarantinable diseases. This section, however, does not designate the period of quarantine. This would leave the period of quarantine up to the judgment of the board of health through its executive officer, the health commissioner.

"Scarlet fever is not a disease; it is a symptom complex. If an individual is infected with a strain of the hemolytic streptococcus that produces an erythrogenic toxin, and the individual happens to be sensitive to that toxin, a rash results and the diagnosis is usually made of scarlet fever. If no rash develops the case is usually considered to be that of a streptococcal infection of the throat. There seems little point in singling out one particular symptom complex as the result of a hemolytic streptococcus infection for the application of stringent methods of control. Furthermore, there is no evidence to show that stringent isolation of cases and quarantine of contacts has accomplished any appreciable reduction in the incidence of streptococcal infections, including scarlet fever.

"Because the former state regulation for the control of scarlet fever appeared to be illogical in view of scientific facts and modern methods of therapy, the new regulation was promulgated."

Wilmington—Dr. V. E. Hutchens has been elected chairman of the Clinton County Board of Health.

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Fewer Occupational Disease Claims Filed in 1945 Report Shows

In presenting statistics for 1945, the Ohio Industrial Commission reports that for the first time since 1938 there has been a reduction in the number of claims filed for occupational diseases in Ohio.

In an article appearing in the *Ohio Industrial Commission Monitor* for April, Dr. W. E. Obetz, medical adviser to the Division of Safety and Hygiene of the commission, attributes the reduction largely to the decrease in employment and exposure following the termination of the war.

Last year total claims reached 6,112, against the maximum of 7,949 occurring in 1944.

Industrial dermatitis claims, as in previous years, led in frequency with 4,084, or about 65 per cent of the total. Many of these claims were due to war activities, especially dermatitis resulting from contact with oil and cutting compounds. Oils and cleaning compounds used in the manufacture of shells was such a factor, and since the cessation of this type of employment there has been a marked reduction in claims.

Dr. Obetz hopes that the reduction in exposure together with the proper precautions, such as cleanliness of the workroom and personal cleanliness by efficient use of proper washing facilities will result in still greater reduction.

A slight decrease in lead poisoning has been noted, as well as in the number of cases of tenosynovitis and bursitis.

Silicosis, which according to Dr. Obetz, continues most important from the standpoint of death claims and permanent disability, was reduced by 24 claims, but the total of 353 in 1945 was "still much in excess of what it should be".

The article states that foundries are responsible for about 57 per cent of the silicosis claims filed, with the ceramic industries following second with about 30 per cent.

There was a marked reduction in the number of claims filed for the miscellaneous group of industrial poisons. This is especially true in those operations engaged in the manufacture of munitions containing toluene and its products. The claims filed in 1945 were as follows: ammonia, 3; benzol, 3; berylium, 24; brass and zinc, 2; carbon monoxide, 2; carbon tetrachloride, 11; halogenated hydrocarbon, 2; petroleum products, 3; synthetic rubber, 4; toluene and derivatives, 11; unclassified, 35. This is a total of 98, as compared with 175 claims in 1944.

Report Must Be Signed by Licensee

In a general order dated April 18, 1946, the Ohio Industrial Commission ruled that neither compensation nor medical fees will be paid on a claim unless the application is signed by a person licensed by the Ohio State Medical Board.

Lima—Dr. H. H. Brueckner has resigned his position as superintendent of the Lima District Tuberculosis Hospital, effective September 1, according to a newspaper report.

Marion—Dr. J. W. Wilce, director of the Ohio State University Health Service, addressed the men of the First Presbyterian Church Brotherhood May 20 on the subject, "Hercules and Hippocrates Today". Dr. Wilce described the 25-point Health Program for Ohio which was adopted by the House of Delegates during the Centennial Anniversary meeting of the Ohio State Medical Association early in May.

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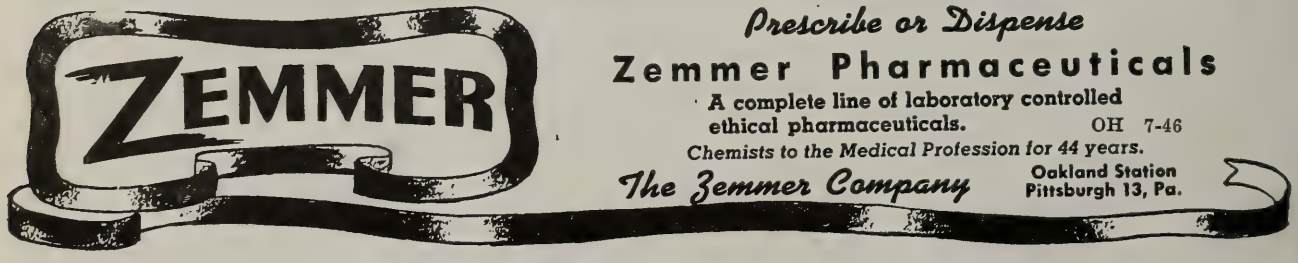
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The Ohio State Medical Journal

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Vol. 42 August, 1946 No. 8

JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.*

GEORGE H. SAVILLE, *Asst. Managing Editor*

HART F. PAGE, *News Editor*

Considerations On Poliomyelitis

JOHN A. TOOMEY, M. D.

IN our district we may have an occasional case of poliomyelitis around the middle of May, but ordinarily the disease does not appear much before the first or middle of July. During the past few weeks, we have had three patients with poliomyelitis, one of whom died. It is, therefore, timely for us to start thinking about poliomyelitis and to prepare ourselves for any possible eventuality this summer. Severe epidemics are already being reported in the Southeast and the mid-Southwest, in Florida and Texas, respectively.

One would think from comparative immunologic data that the number of cases would be less, following our recent epidemics, and that all susceptibles in an area should have become immunized by this time, but unfortunately the disease re-occurs in localities where it has previously appeared. Collins[1] states that the 15-year average from a number of localities is approximately 5.7 cases per 100,000 in the white population. Fifteen years ago most of the individuals who had the disease were children, perhaps under five years of age. It is now apparent that this infection is no longer limited to childhood, but one in which the age incidence is gradually rising, a disease which may strike patients even as old as 40 to 50 years.

It is likewise true that the number of patients who contract the very severe type, i. e., bulbar poliomyelitis, is increasing, although fortunately the mortality rate has not also increased. Recently it has been about 28.5 per cent in our experience as compared to 75 per cent which befell the same type of patient we saw in epidemics 10 to 15 years ago.

The Author

● Dr. Toomey, Cleveland, Ohio, is a graduate of Western Reserve University School of Medicine, Cleveland, 1919; and is prof. of clinical pediatrics and contagious diseases, Western Reserve University School of Medicine.

COMPARISON WITH RHEUMATIC FEVER

What intrigued me most about Collins' article was that he compared poliomyelitis with other diseases, particularly rheumatic fever. In the group he studied he found that there was less rheumatic fever than poliomyelitis amongst children under five, but from five to 20 years the rates might be higher for rheumatic fever if only those poliomyelitis patients that are paralyzed were considered for comparison. If, however, all types of poliomyelitis are included, it was astonishing to read that the attack rate for poliomyelitis is about the same as that for rheumatic fever and, strange to relate, between the ages of 20 to 24 years, the poliomyelitis rate was actually higher. These are figures that one should remember when taxed with the fact that the cardiac patient is being neglected for the poliomyelitis patient.

Another interesting fact was that amongst all persons under 25 years with orthopedic impairments, exclusive of lost limbs, i. e., lost arm or leg, 30 per cent was caused by poliomyelitis—

Presented at the Epidemic Preparedness Conference, sponsored by The Ohio State Office, National Foundation for Infantile Paralysis and the Ohio Department of Public Health at Columbus, June 13, 1946.

nearly one-third of the crippling being due to this one disease alone. Collins found that when he considered only persons under 15, 28 per cent of the crippling was caused by poliomyelitis; for those under 5, 14 per cent; from 5 to 9, 30 per cent; and from 10 to 14, 31 per cent. In short, one third of the crippling in children up to 15 years is due to poliomyelitis. The profits from the modest investment which the public makes should be reflected in the near future in the lessened numbers of institutional patients. This one should remember when confronted with the fact that other cripples are neglected for the poliomyelitis patient.

IMPORTANCE OF EARLY TREATMENT

There are other reasons why we should prepare at this time. I think that by now we have come to realize that the best treatment in this disease is early treatment, that many children's lives can be saved if seen early and if the disease is recognized early; that many disabilities can be averted with early and persistent routine care. One can see the importance of an early and an accurate diagnosis.

Considering the total United States, the annual death rate per million in cities of 100,000 or more was 4.5; the rate for moderate sized cities (10,000 to 100,000) was 6.8; the rate for towns 2,500 to 10,000 was 10; for places under 2,500 and rural areas, 8.0 per million. There is no difference in the type of poliomyelitis between that encountered in the city and that in the country. The difference lies in the fact that in the larger centers the children are apt to be diagnosed and treated more quickly. They usually are organized in these areas to care for emergencies and alerted to make a diagnosis early. It is true that many patients are incorrectly diagnosed, but it is better to be suspicious than always correct. Despite the fact that rural areas have a lower mortality rate than small towns, it is still not as low as in the cities. The only difference is in preparedness. This alone should make us think, because by being alert we may lessen the mortality from 8 to 10 to 4.5 per million.

Many pediatric problems are involved in the care of the patient in the acute stages and it is important to realize that the losses from the disease occur during the first few days following its onset, losses which sometimes may be avoided.

Patients are admitted to the Contagious Hospitals and discharged or transferred or further care, if needed, arranged for, at the end of 21 days, the supposed quarantine period. They could be admitted to any general hospital. It is during these 21 days—in fact, the first four days—that most patients die. The National Foundation for Infantile Paralysis has initiated programs everywhere to care for and to avoid crippling aftereffects and is now reaching backwards to extend a helping hand at the first sign of infantile paralysis, so that even the mortality rate may be lowered. This alertness is to be brought about by education, by educating the hospital administrators, physicians, nurses, and the public that this disease is not so contagious and that any hospital can admit it.

OBJECTIVES OF TREATMENT

The objectives in the treatment of acute poliomyelitis are: To save the patient's life; to stop the spread of the paralysis; and to treat involved muscles in the quiescent stage. Pediatric nursing care can be of great value in the early disease. At this time the care is nursing and pediatric. If the patient with bulbar involvement survives for 48 hours without an extension, the disease usually stops spreading and recovery, if the disease is solely bulbar in type, is complete. If there is an extension, these patients and those with involvement of the intercostal and diaphragm muscles are the ones who die.

Some patients have respiratory difficulties, but not every patient should be placed in a respirator. First of all, it is of primary importance to know how a respirator operates and its mechanism. If a patient can't get air in, he becomes cyanotic and gasps for breath. A patient then may be unable to breathe because he can not move his diaphragm or intercostal muscles. The bellows is not active. He suffocates if nothing is done to help him and, therefore, he should be put in a respirator. The patient who has bulbar paralysis will also have trouble in getting air in, but for a different reason. Since the throat muscles are paralyzed, he can not cough out the material collected there, and, therefore, insufflates it into the trachea and may actually drown in his own secretion. This latter patient should never be put in a respirator, unless he also has concomitant involvements of the intercostal and diaphragm muscles. All he requires are an aspirator and postural drainage and in a few moments he is breathing normally again.

Some individuals not familiar with respirator treatment use it as a respiratory splint and often have difficulty in stopping its use. No matter how sick the patient, some effort should be made by the patient each day to test his respiratory muscles without the aid of the respirator even though it be for only a period of one-half minute.

GASTRO-INTESTINAL TRACT

Clinically, individuals with urinary retention and overflow dribbling may have extensions of their paralysis as well as children who have retractable constipation with retention. Unless

the bladder and rectum are washed, the virus will be found in maximum amount in the stool. Because of these facts, the first thing done is to clean out the gastro-intestinal tract from top to bottom with salts and enemas, the latter two or three times a day for the first few days in the simple spinal case. It is our practice at the Cleveland Contagious Hospital to clean out the bladders of those patients who have inability to urinate at least three or four times a day. I have experimental evidence as well as clinical for so doing. One of the complications of sulfonamide therapy has been stones produced by the drug which block the passage of the ureter or the tube which carries the urine from the kidney to the bladder. The blocking was so similar to that in poliomyelitis patients with retention, that the possibilities of an experiment were suggested. A number of monkeys were fed sulfanilamide until the stones blocked the ureters, producing much the same thing mechanically as is produced with bladder muscle paralysis in poliomyelitis. After a period when sulfonamide had been used (usually four days), we injected poliomyelitis virus into a comparable number of untreated and sulfonamide-treated animals. Those that were treated with the sulfonamide drugs came down with the disease from three to four days sooner than did the untreated. Thus, two points were shown: (1) That retention aggravates poliomyelitis; and (2) That the sulfonamide drugs have no place in the therapy of this disease.

It is the little, but important things, done at the right time that count—aspiration of the mucus from the throat by mechanical aspirators, postural drainage, sedation, oxygen, etc. There are many other "little" things that are important, but it would take too long to discuss the details. Among them is fluid, how much should be given, when it should be given, and so forth. There is a difference between what can be given to a patient with bulbar poliomyelitis and that which may be given to an individual with the usual spinal type of the disease. Care must be taken not to give hypertonic or hypotonic saline infusions, transfusions, specific serums, etc. The greatest attention to nursing details is important. Curiously enough, pain is not an important factor in the early stage.

THE PATIENT

The patient's confidence must be won as well as the confidence of his parents, and they must be made to realize that to get the best possible results, the child may have to be treated in an institution for as long as two years. I have learned by experience that no matter what the incentive is, or how much courage or morale the patient has, or how intelligent he is, once he goes home and is away from strict control and supervision, something is lost. Substitutions and deformities may occur. In all procedures, the patient should move rhythmically, if necessary with the aid of crutches, braces, and the like. The important point is not to use the good muscle, but to educate, train, activate, and hypertrophy the poor muscles. It may seem paradoxical to you, but the purpose of all therapy is not to develop maximum strength, but primarily to achieve rhythmic movement.

Many things we do in life are acts motivated by instinct or conditioned reflexes. We walk thus and so because we are conditioned by observation to walk thus and so. Perhaps we might just as well have walked on our hands and knees. People in Swiss cantons where the goiters are large do not look upon a goiter as a cosmetic defect. There it is a sign of beauty, conditioned as they are to its prevalence. And so it is with people who have weak muscles; they move against advice, they and their parents being satisfied that they can move. In moving, they utilize the aid of strong muscles and do not use the weak ones, as a consequence of which the strong muscles used hypertrophy, the weak and inactive ones atrophy, and in no time at all the patient has acquired a new pattern of walking and a deformity. In order to bring him back to normal, the deformity has to be corrected first and then only after the deformity has been corrected can the re-education of muscles be started. It is almost a hopeless job. How much more intelligent is it to realize that the important thing is to re-educate early and that persistent, supervised training is necessary to avoid the deformity. This is an expensive proposition but it pays in the long run and the taxpayers have a lessened burden upon them inasmuch as the patient has not been rendered hopelessly paralyzed by disease and that in all probability he will be either partially or completely able to return to his place in the community. Early diagnosis, early and persistent treatment, and orthopedic care should be our watchword.

BIBLIOGRAPHY

1. Collins, Selwyn D.: The Incidence of Poliomyelitis and Its Crippling Effects, As Recorded in Family Surveys. Public Health Reports, 61:327, March, 1946.

The antibiotics have as one of their outstanding virtues the relative freedom from toxicity. This has been the clinical experience of those most widely acquainted with their use. The case presented, in which over 11,000,000 units of streptomycin was given in 27 days without any apparent deleterious effects, fits in with observations made by others.—J. Lawn Thompson, Jr., M.D., and Harry H. Wagenheim, M.D., Camp Pickett, Va.; Medical Annals of the District of Columbia, Vol. XV, No. 6, June, 1946.

Evolution of Poliomyelitis Treatment

EDWARD HARLAN WILSON, M. D.

THE medical profession must constantly ask itself, in the treatment of any disease entity: Is this form of treatment worthwhile? Would the patient who is suffering from the particular illness be as well off without the treatment as with it? These two questions are especially pertinent in considering the treatment of poliomyelitis, since all forms of treatment evolved are empirical, and difficult to measure by any scientific method. This difficulty proceeds from the great variability of the effects of the disease in all individuals who contract it, and the inability to predict accurately the permanent effect of the disease in a given individual in all but the most severe forms of the disease and in some of the very mildest. Certainly we do not have at this time any specific treatment of the disease at onset as we do have in diphtheria, meningitis, streptococcus, and similar infections. Research does point to a virus as the cause of the disease but has not as yet led us further along the road of sure understanding. We are even uncertain as to the manner in which the disease spreads and we are very uncertain as to whether any of the methods which have been used in the onset stage, such as injection of parental blood, or transfusion of convalescent blood, are of any real value. Until the hoped for development of a specific treatment which, used during the acute stage, will prevent or greatly modify the effects of the disease, we are faced with the treatment of the resulting paralysis and the attempt by various methods to modify the paralytic effect of the disease in the affected patient. It is, therefore, concerning the treatment of the paralyzed patient that we ask the questions: Does treatment help the patient to a better result? Is he better off with treatment than without it?

THE PAST 30 YEARS

In order to answer these questions, we must look backward over the past 30-odd years, and briefly survey what has been attempted, how treatment has been formulated and modified, and come to an understanding of the present attitude toward more recent forms of treatment. The modern history of poliomyelitis began in 1914 when the first great epidemic swept the country, to be followed in succeeding years by severe epidemics localized geographically, but affecting great numbers of children and adults, while there has always been the steady endemic form of the disease which occurs in the summer of each year all over the country. While not so spectacular as the larger epidemics, the sum total of this scattered form is considerable. Thirty-odd years ago, the Harvard Poliomyelitis Commission was established by the State of Massachusetts, to care for and to study polio, and to formulate a method of treatment. A clinic was established at Boston Children's Hospital, and the findings there formulated became the basis of treatment all over the country during the ensuing years. The clinic had the advantage of financial backing and good organization. Clinical material was assured by interlocking, outlying clinics, and travelling clinics were furnished to the smaller New England States. All of this, in the hands of a capable staff, resulted in the accumulation and classification of much information from which principles of treatment were evolved.

Very early in the resulting study, it was noted that there was a stage of pain in the limbs during which any attempt directed toward exercise so increased the pain that such attempts had to be discontinued, and this stage, it was noted, lasted from a few weeks to months. Heat in one form or another was soothing to the patient and was habitually used. Active therapy was not given until subsidence of the painful stage. A second important finding was that the affected parts of the body tended to deform severely and wherever such deformity occurred there was very little return of power to the muscle serving that part. This tendency toward severe deformity soon loomed very large indeed in everyone's mind. The patients often were not seen until some time had elapsed since onset and consequent deformation naturally suggested the use of splints to prevent such deformities, early in the disease. Again it was found that patients who were treated thoroughly under favorable conditions would not infrequently return with deformities, which had developed late in the disease, after they had been returned to their homes.

I can personally testify to the state of mind produced by such a state of affairs. Twenty-two years ago, when I first met this problem on my own responsibility, there had been little

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education of either the profession or laity toward meeting this problem. There were very few public clinics and rarely were cases brought in during the early stages of the disease. As a result most of the patients whom we saw were severely deformed, and in the deformed limbs there was very little muscle power to be found. I once estimated that over 60 per cent of corrective surgery then performed at Children's Hospital was done to correct deformities. Even after the deformity was corrected, we had very little to work with as such limbs were almost totally weak and ineffective for use. This was, of course, a tragic state of affairs. The logical solution was obviously that of holding the limbs in straight positions by means of splints until all chance of deformity had passed. Since splinting alone, while preventing deformity, would not encourage return of strength and motion, exercise was added and increased within the ability of the weakened muscles to endure it. Exercises were evolved which took advantage of the slightest flicker of muscle contractibility. These were administered by trained physical therapy technicians.

As experience with poliomyelitis increased, conception of what we could expect in return of muscle power under favorable conditions of treatment became clear. Pathological study revealed that the anterior horn cells of the cord, from which issue the long motor nerves, are sometimes irrevocably destroyed by the disease while at the same time others, after being severely affected, recover their function. Since a single nerve trunk is made up of hundreds of fibres, each served by a single nerve cell, the final function of the nerve itself will depend on whether any or all of the horn cells recover. If none of them recover then we have a degenerated nerve and a paralyzed muscle at the end of the nerve. If half of the cells recover then part of the nerve will regain function and that portion of the muscle which is served by the recovered nerve fibres will return to contractibility. The net result will be a muscle which is at least greatly reduced in power. It is logical, therefore, that treatment is concentrated on the muscles which show some return of nerve function. Exercise judiciously given, should gradually restore the ability of the muscle to respond to nerve impulses. Furthermore, the remaining portion of a damaged muscle may by exercise be so enlarged that it will make up in many instances for that part of the muscle which is damaged, to at least a partial degree. Therefore, we can summarize briefly that exercise, begun as early as possible, is indicated, in order to restore partially or temporarily paralyzed muscles to their best possible function.

There is no doubt that the occurrence of deformity early in the disease is a serious deterrent to muscle recovery even when there is some restoration of nerve function. We now recognize two main reasons for the development of deformity. The first of these is muscle contracture. This appears during the painful stage after onset from a spasm reaction of the muscle. If this is allowed to go on too long, unrelieved, there results a permanent shortening of the muscle, possibly the result of involvement of its lining membrane. Credit must be given to Sister Kenny for observing and emphasizing the importance of this factor as a cause of increasing deformity for, as she has pointed out, the contracture easily becomes permanent and when this happens the affected muscle does not extend as fast with growth as its fellows, thus resulting in a gradually increasing contracture deformity which does not respond well to splinting. It has always been recognized that in such deformities there is permanent loss of muscle function which is far greater than when the contracture spasm is relieved by proper treatment during the early stages of the disease and I believe that it usually can be relieved. The other type of deformity results from a permanent disturbance in normal balance as a result of paralysis. When the muscles of one side of a limb retain their normal power and tone, while those on the opposite side are weakened or totally paralyzed, there is bound to be a drawing over of the limb toward the more powerful side. During the growing years such deformities can be controlled only by braces. When growth has been largely attained, carefully planned surgery will usually permit stabilization of the affected part in normal position, and the discarding of braces.

PRESENT-DAY CONCEPTS

These briefly stated factors in the treatment of poliomyelitis have gradually evolved from the observations of a great many physicians and technicians who have closely observed the disease and recorded the reaction of large numbers of patients to various methods of trial treatment, some of which have stood the test of time while others have had to be discarded. Among those who have made contributions to present day treatment is Sister Kenny, the Australian nurse. It is to the credit of American medicine that Sister, who had been refused a hearing in other parts of this world, was not only welcomed in this country, but was given a well-equipped clinic wherein she might demonstrate her techniques. She was given thorough cooperation by orthopedic surgeons and physicians trained in physical medicine. She has made important contributions to treatment and her techniques are today taught and used in a majority of the

poliomyelitis centers. She deserves the credit for the emphasis, now universal, on early treatment of muscle pain and the modification thereby of consequent disastrous contractures. We have been influenced by her to reduction of splinting to a minimal amount and the dependence on hot packs and moderate exercise as a better method of combatting early deformity. It has been impossible, however, to accept the claim that her method is in any sense a cure, for there remains, after the use of her method, the same percentage of partially paralyzed patients as before. The fact stated earlier in this paper is that in the end, the amount of paralysis and its location depend on the number of anterior horn cells which have been destroyed at the onset of the disease. Treatment benefits those muscles, or that part of a muscle, which is, so to speak, still alive and is not in any other sense a cure of the disease. The word "cure" can only be used when a specific treatment is developed, which administered very early in the disease will radically modify the paralytic effect of the disease. Nor are we able to agree that the Kenny technique is a rigid system which must not be subject to changes and improvement. To so regard any method of treatment would take medical philosophy back to the middle ages. We have not been able to accept her interpretation of aspects of the disease where such interpretation ignores the pathological facts. Therefore, Sister has gone her way alone rather than as part of a team.

During the past few years those of the medical profession in Columbus upon whom has rested some of the responsibility of rehabilitating the victims of poliomyelitis have felt the need of securing earlier treatment of all of the patients and of concentrating this care. By so doing we believe we should be able to secure better organization and more adequate study of the effects of the disease, and its response to various forms of treatment. A year and a half ago, in association with the Columbus Chapter of the National Foundation, such organization became possible. With the interested cooperation of the Children's Hospital and the College of Medicine, we were able, in the interest of the Foundation, to form a group team for the study and treatment of the disease. Facilities were set up at Children's Hospital and it was arranged to receive not only children but all adults affected by the disease. The age limit for admission to the Hospital was obligingly waived by the Hospital Trustees in the public interest. In forming the team it was felt that no one branch of medicine could handle the problem alone and that the disease at various stages presented problems pertaining to all of the specialties of children's diseases and that to turn the care of the disease over to one branch alone would expose the conduct of treatment and observation to serious weakness. It was felt, on the other hand, that a complete group representing all of the medical viewpoints might very well help all of us to a better understanding of the problems to be met in bringing about improvement of treatment. The group as formed includes, and wishes to include, any physician who is interested in the problem. Pediatrics, pediatric research, division of infectious diseases, orthopedic surgery, psychiatry, neurology, physical medicine, and public health are all fully represented. On admission, each patient becomes the diagnostic problem of the pediatric division and receives a thorough study, including spinal fluid examination. Actual physical treatment is the responsibility of the department of physical medicine with the advice and consultation of members of the orthopedic and pediatric staffs. As treatment is completed to a point where the patient may be discharged from the hospital, he becomes the responsibility of the orthopedic division with the continued cooperation of physical medicine. Once a week during the hospital stay, group rounds are held with frank discussion of current problems.

OUR TASK

Since we are treating the effects of a disease which in a given patient may result in varying degrees of permanent paralysis in spite of our efforts, we are in no position to boast about the effects of treatment or to regard the occurrence of the disease as anything less than tragic. Yet, we as a group have realized that we can do very much to rehabilitate and modify some of the effects of the disease. In preventing deformity and restoring partially affected muscles to better function, we are able to restrict the effects of the disease to those muscles which are actually paralyzed and thus enable the patient to secure the best result possible to him. By proper follow-up, we are able to check the effects of unbalanced pull in bringing about deformity. Finally, surgical procedures become applicable to a majority of paralyzed patients, thus permitting them to become more useful individuals and to rid themselves of restrictive braces. Unfortunately, we will always have a small percentage so severely paralyzed that none of these methods is applicable. Even they, through the State Department of Education, can receive schooling either at home or in special schools and still later be trained by the Bureau of Vocational Rehabilitation for some form of gainful occupation. On discharge from the hospital all except private cases should come under jurisdiction of the Crippled Children's Bureau for future management and follow-up.

Treatment and the Results of Treatment In Anterior Poliomyelitis

SHELBY G. GAMBLE, M.D.

IT is realized that there are many manners and means of treating anterior poliomyelitis. Since this condition is generally accepted as being a virus disease, it must be understood that to date there is no specific therapy known, drug or otherwise, that destroys the virus or controls its spread within the body. In other words, one can not prevent the development of, or lessen the severity of, paralysis in a patient by any means known at present. If the motor cell in the anterior horn of the gray matter of the spinal cord is completely destroyed, the paralysis that results will be permanent. The fundamental principle on which our treatments stand is the fact that usually only a relatively few motor cells are completely destroyed. Motor cells are involved to varying degrees, short of complete destruction and so recover or return to function in a proportionate manner. It is this pathological characteristic of the disease process that has been the foundation of our treatment program; namely, to keep the patient generally, and the part locally, in as good condition as possible while awaiting return of function of the motor cells which have been only temporarily or partially involved. Then, depending on how much function does return, we may by a careful program of treatment, either strengthen the involved muscles; or still more important, teach the patient to use efficiently what he has left; as coordination and balance are of far greater importance than strength alone.

It is agreed that during epidemics, that all non-specific febrile illnesses be regarded with suspicion and placed under medical supervision. This does not necessarily imply hospitalization. In such cases, many of whom undoubtedly will eventually have a diagnosis made of abortive poliomyelitis, there is the potentiality at least of some degree of paralysis developing. It is therefore important, for general empirical reasons alone, that the patient be protected by bed rest from exhaustion and possible trauma during this period for whatever effects, if any, it may have on the future developments in the individual case. At least, such a program can do no harm.

It is not my intention to make dogmatic statements regarding therapy in anterior poliomyelitis as there are so many arguments, pro and con, regarding many aspects of any treatment program. On the other hand, because of the nature of the disease condition we are discussing, there is no one as yet that has the final answer to the problem. A condensation of the treatment program at the "Polio-Center" here in Children's Hospital, as carried out under a group advisory committee consisting of orthopedic surgeons, pediatricians, internists, and neurologists will be outlined for your consideration.

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For convenience of discussion, such a treatment program may be divided into three stages: acute, convalescent, and chronic. Everyone must realize that there is no sharp division or definite time when a patient may progress from one stage to another.

THE ACUTE STAGE

The acute stage follows the prodromal upper respiratory or gastro-intestinal symptoms. After a presumptive diagnosis has been made and various tests completed, the object of treatment is to relieve pain and prevent deformity. This consists primarily in good medical and nursing care. The acute stage is usually the period of isolation with isolation nursing technic and this, of course, has some effect upon treatment procedures that can be carried out.

Bed positioning is of great importance and we insist on absolute bed rest in a natural rest position, either prone or supine, with arms at the side, a board under the mattress, a board at the foot, and the feet against the board at right angles. Depending on the degree of toxicity present, some leeway is of course given in minor details.

Moist heat in the form of hot packs is used to relieve pain and muscle contraction when present in the muscles involved. These are routinely ordered on admission, when indicated, except in cases that are very toxic with high temperatures. We feel that the temperature should be under 103°F. before hot packs are applied, as, in any condition with a high temperature, the general heating which results from packing might be sufficient to cause further rise

in temperature that would be unfavorable to the patient. In addition, the majority of cases of anterior poliomyelitis are in children with comparative instability of their temperature regulatory mechanism.

When hot packs are used, either as a full pack or prone pack, they are applied at intervals of from 15 minutes to two hours, depending on the acuteness of the condition. The average is from six to eight complete packs; usually from 8:00 A.M. to 8:00 P.M. In severe cases, packs may be applied around the clock. However, in the majority of instances, it is more desirable for the patients to gain the needed and necessary rest during the night; as the handling incidental to packing and the packing itself is quite exhausting to them.

When indicated, sand bags, pillows, blanket rolls, and various types of splints are used to maintain proper positioning in addition to whatever secondary effect the packing may have in this respect. As a general statement, hot packs are continued on an individualized schedule for each patient until all pain and abnormal contraction in the muscles has subsided. This period is variable and in certain patients with residual tightness, hot packs may be continued for months. We have also tried in our limited number of cases the use of prostigmine and curare. We have not had the highly favorable results as noted by others, but further trial and observation is indicated. As new drugs are developed, chemotherapy is indicated on a therapeutic trial basis. Time alone will tell their value.

Coincidental with the beginning of hot packs, passive and active assistive motions of all joints of the body, through as full an arc of movement as tolerated, is carried out to prevent as much as possible stiffness of the joints and tightness or contractures of the muscles. By means of these same movements, muscle re-education is initiated and carried out during the entire treatment program in one manner or another. As the pain subsides, mild graduated stretching is begun with any muscle that shows tendency toward residual tightness.

It is probably best to consider respiratory involvement now as it fits more easily into the picture here than elsewhere. Basically there are two types of acute respiratory paralysis; the bulbar and the spinal or intercostal type; a third being the combination of the two. In both types of respiratory involvement, the primary difficulty encountered in treatment is to get the air into the lungs. As we all know, the reasons for this difficulty in inspiration in the two types, are entirely different.

THE BULBAR TYPE

In the bulbar type of respiratory involvement, the higher centers in the brain are involved and the muscles of the throat and larynx are affected by the paralysis. The difficulty in inspiration is the result of the mucous in the throat which obstructs the passage of air as the patient can not expectorate this thick tenacious material. Treatment is more or less limited to restricting the fluid intake in order to reduce the amount of mucous formed, to raising the foot of the bed and turning the patient's face to the side so that the mucous will tend to drain spontaneously, and to aspirating by means of a suction machine the mucous from the patient's throat. A respirator can not be used in these cases, as the negative pressure produced will aspirate the mucous in the patient's throat down into his lungs. If the obstruction is complete, the patient will die immediately from asphyxiation. If the obstruction is incomplete, the patient will usually develop fatal bronchopneumonia. As a general statement, the first 24 to 48 hours is the critical period in a patient with bulbar type of involvement. If the patient survives this period, his chances are good except that he must be carefully guarded from respiratory infections until all signs of involvement have disappeared. Quite often patients with bulbar poliomyelitis have little other involvement although in a few there may be varying degrees of peripheral weakness or paralysis. Also, most patients with bulbar symptoms, if they survive and the mortality is high, have a complete or almost complete regression of all such involvement. As stated previously, little except the necessary measures to combat the mucous is attempted during the initial stage. After this period, the patient is treated, in general similar to any other patient except for modifications that may be necessary in each individual case.

SPINAL RESPIRATION PARALYSIS

In the spinal or intercostal type of respiratory paralysis, the muscles of inspiration, primarily the intercostals, are affected so that the difficulty here is in elevating the chest so as to let air into the lungs. The air passages are free of the obstructing mucous noted in the bulbar type.

It is therefore in the spinal or intercostal type of respiratory paralysis that the respirator is of greatest value. The mechanical production of a negative pressure elevates the chest and allows air into the lungs. Usually, release of the negative pressure will accomplish expiration by the weight of the chest itself. Occasionally positive pressure is used to help the patient cough or to expel mucous when necessary. The respiratory rate, of course, varies with the age of the patient, the degree of involvement, and must be adjusted to the patient. As in all cases of respiratory paralysis, there is a marked increase in susceptibility to U.R.I. and these patients must be protected as this is the usual fac-

tor in producing a fatality after the initial critical stage.

Patients with spinal or intercostal type of respiratory difficulty, usually have varying degrees of peripheral involvement in contrast to the bulbar type. Packing and other treatments are carried out just as in the case without respiratory involvement. This is performed in the respirator with varying modifications until such time as the patient can be removed from the respirator for a sufficient interval to do any of many procedures.

It is of utmost importance that patients in respirators be watched closely, and as soon as their condition permits, they should be removed from the respirator for gradually increasing periods of time. If this is not done early, a patient will develop a dependency or fixation neurosis with regard to the respirator and become difficult to handle. The same thing is true about having constant attendance from personnel, and later, with regard to having the respirator always by the bedside.

The attention and care that must be given to a respiratory case is great. The use of the respirator is gradually discontinued as the patient's condition permits. We attempted to evaluate the length of time that the patient can be out of a respirator by the usual signs of respiratory embarrassment, the vital capacity, and any exhaustive symptoms that may develop.

In the combined spinal-bulbar type of respiratory involvement, one attempts to determine which type predominates and if the mucous is sufficiently little so that a respirator can be used. Needless to say, the mortality is almost 100 per cent in such cases.

THE SECOND STAGE

The second stage is spoken of as the convalescent period. This period begins when the acute symptoms have subsided and ends when spontaneous improvement is no longer observable. It may be from a few months to two years in duration depending upon the amount of residual present. The two-year limit is a generally accepted principle, based entirely on years of observation in the past of patients with poliomyelitis by competent men. Most patients will show maximum improvement as to individual muscle gains during this time. After two years it is using efficiently what one has left, as will be discussed later.

It must be realized that after the acute stage, or even with so-called abortive poliomyelitis, even though there is no demonstrable residual weakness, that such patients have had a serious systemic infection and must have a period of six months or more of decreased activity in which to recover completely. These patients have been through an exhausting ordeal which has used up most if not all the natural reserve in the body. It is not uncommon to notice little improvement in a patient with severe involvement for six to eight months; or until nature has had an opportunity to marshal its forces again. Most patients, of course, show their most rapid gains during the first six months and then improvement is slower. Patients without residual must be ambulated gradually with periodic checks to prevent exhaustion, and to determine if any borderline muscles weakness will become apparent with increased activity. If such occurs, corrective measures must be undertaken before deformity develops.

PHYSICAL THERAPY

The convalescent stage is primarily one of good physical therapy. The object of treatment with patients with definite residual, is to keep the joints limber, keep the muscles in good general condition as far as possible while waiting until the innervation returns if this is to occur, and to prevent deformities and contractures. This is not always possible with the best of care as occasionally deformities, etc., are progressive no matter what is tried. However, the general statements made are true in the average case, as most patients show varying degrees of improvement over the original weakness or paralysis; provided, of course, as stated above, that the motor cell is not completely destroyed.

The paralysis and weakness in poliomyelitis is spotty which is typical of the involvement. By nature of this irregular involvement, changes will occur at irregular intervals so that no set routine can be followed. Instead patients must be examined and observed frequently.

The convalescent period is one of rest, passive, assistive and active exercise both in and out of water, muscle re-education, and the avoidance of muscle substitutes. It is one of gradual ambulation and increased activity as indicated. Braces, corsets, crutches, etc., may or may not be indicated depending upon the individual case. Such apparatus when necessary is always obtained through conference with and ordered by the orthopedic surgeon in attendance on the case. A certain amount of muscle power is essential to perform certain tasks or use certain apparatus. However, in general, muscle balance and coordination are of prime importance; not strength. Re-education of muscles requires a great deal of patience and perseverance on part of the patient, the family, and all persons related to the treatment program. Even though muscles may appear normal early in the program, there is not the normal reserve present so that fatigue is an important factor to be avoided.

RESIDUAL STAGE

The chronic or residual stage is the one in which natural improvement is diminishing and

treatment is concentrated on the prevention and correction of deformities. This stage is primarily orthopedic in nature, and lasts more or less indefinitely. Apparatus must be checked and replaced at intervals as well as to determine if there has been any changes in the picture as time goes on. When a patient is in the growing period, such check-ups must be very regular and at frequent intervals in order to make such changes as may be necessary, not only with regard to changes in the muscles, but also to over-all changes of the body. This is why a workable follow-up program is so important in these patients. Otherwise, much of what has been accomplished by good treatment, or what one reasonably expects to accomplish, is lost when the patient disappears during the early years when we have our best chance of doing something for them. Deformity results from muscle imbalance. The prevention of deformity is much easier than the correction of deformity and therefore explains why the principles of treatment in the early stages of the disease are so important.

Poliomyelitis is, in general, a problem of body mechanics with stresses and strains affecting the normal as well as the involved parts of the body. The real test of muscle function is how well a patient is able to take care of himself and make a living. It is necessary to observe frequently the combination and substitutions as the muscle groups change in power, etc., when different stresses and strains are encountered. Any apparatus that is worn may also change muscle action.

The aim to be achieved in walking is to attain as smooth a gait as possible with a minimum of effort and a maximum of appearance. This does not mean that all apparatus should be eliminated. The purpose, as always, is to prevent and correct, not develop deformities. It is a matter of exhaustion, other things being equal, that determines whether a patient is adapted to crutches, cane, wheelchair, braces, or confined to bed. Of course, as apparent to all, a patient must have the use of certain specific muscles to a specific degree depending upon the type of apparatus under consideration. Every patient must be given the chance to walk so that he can determine to his own satisfaction whether or not it is too great an effort for him. Otherwise he may never adjust himself to his condition and make his future life worthwhile.

Orthopedic surgery procedures are very important in the residual stage of poliomyelitis. The purpose of such procedures is reconstructive, i.e., to improve the motor function and stability of the part, and to correct deformity. Numerous corrective operations have their specific indications and may include muscle transplants, arthrodesis, osteotomy, or plastic measures.

SUMMARY

The results of treatment, of course, depend upon the degree of weakness or paralysis that is present. As stated before, there is no specific agent as far as we know that will lessen the degree of paralysis that a patient may have from their infection. Basically everything depends on the degree of involvement of the anteior motor horn cell. Much can be done however to keep muscles and joints in good condition and prevent deformity while waiting the return of function of the motor cell. If this occurs completely the period of care is then markedly shorten. If the return of function is only partial, a varying amount of help can be given so that the patient may be able to use whatever apparatus is necessary, or on the other hand be in good general as well as local condition as a preparatory measure to corrective orthopedic surgery. As a broad statement, treatment programs today leave a patient in a far better general over-all condition than some years back. The results today show the effect of scientific physiotherapy and judicious orthopedic surgery when a patient can be controlled and treated properly which includes adequate follow-up. Last, but not least, in consideration of results, is an intelligent patient with a will to improve, a cooperative family, and means of social and economic rehabilitation so that a patient has something to look forward to. This is an aspect of the problem of anterior poliomyelitis, too large in scope for our present consideration, and is only mentioned because of its importance in your thinking.

Treatment of Head Injuries

Ice bags to the head and absolute bed rest is ordered. Restlessness in head injuries is an indication of elevated pressure. It is controlled by sedatives, as: phenobarbital, 1½ to 3 grains; bromides, 15 to 30 grains by mouth or rectum; choral hydrate, 20 to 30 grains by mouth or rectum; or when restlessness is severe with paraldehyde, 3 to 6 drachms by rectum. Paraldehyde is a very effective sedative. If conscious, codeine may be given for headache. Morphine is contraindicated as it interferes with pupillary signs, tends to mask coma and other neurological signs, and is in synergy with the increased intracranial pressure in decreasing the respiratory rate, occasionally even to the point of causing death—E. A. Connolly, M.D., Omaha, Neb.; Neb. State Med. Jr., Vol. 31, No. 7, July, 1946.

Functions of a State Health Department in the Control of Poliomyelitis

ROGER E. HEERING, M. D.

PROBABLY no other disease has as great a demoralizing effect or carries with it a graver fear than poliomyelitis. To a degree, the public has grown somewhat accustomed to outbreaks of this disease so that in recent epidemics the element of panic has not been so strongly evidenced. Yet, there still exists a fear, and probably justifiable, which seems to strike more deeply than in the case of other of the serious diseases to which we are still subjected in epidemic form. It is possible that the fear engendered is stimulated, not so much by the nature of the disease, as by the degree of mystery which surrounds it—the manner of its striking without warning, and the seemingly helter skelter, without rhyme or reason, selection of its victims.

The Author

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HISTORICAL NOTES

The very name by which poliomyelitis is generally known, that of infantile paralysis, is misleading for neither is it limited to infants nor is it in the majority of the cases paralytic. Paralysis, however, is its most obvious and frightening characteristic. In defense of its common name, more than 50 per cent of the cases occur in children under five years of age, and more than 80 per cent of the cases occur in children under ten.

Poliomyelitis was apparently known to the Egyptians as early as 1600 B. C. for atrophy of an extremity is recorded in stone. In spite of its apparent antiquity the first description of the disease was that of Underwood, an English physician, who recorded his findings in 1784. Later, in 1835, Badham described the disease, but it remained for Heine, a German orthopedist, to establish the disease as a clinical entity. Poliomyelitis was epidemic in both Europe and the United States in the latter part of the nineteenth century, and its epidemic character was first noted by Medin in 1887. The infectious nature of the disease was established through experimental transmission by the independent works of Landsteiner and Popper, Flexner and Lewis, Leiner and von Wiesener, and Romer.

Infantile paralysis in the United States was first reported in the medical literature by Caverly, who described its appearance in Vermont in 1894. During succeeding decades, scattered outbreaks of the disease have been recognized and described, and now recognition is general.

FUNCTION OF STATE HEALTH DEPARTMENT

In the control of poliomyelitis, a state health department has certain, more or less, well defined responsibilities—responsibilities which differ little from those with which the state department is concerned in the control of any other of the communicable diseases. In general, these responsibilities are: (1) Isolation of known and suspected cases; (2) Quarantine and observation of contacts; (3) Elimination of causative factors; (4) Coordination of emergency facilities; (5) Education; (6) Research.

We are handicapped at the outset in attempting to establish control measures for this disease, because little is known regarding the true facts of its communicability and the mode or modes of its transmission. Although it has been established as a communicable disease, the actual method of transmission is not definitely understood, although it has been suggested as occurring through droplet infection. It has been suggested that the common housefly may play a role in the transmission since the virus has been found on the fly and since it has also been found in the stools of infected cases. The period of communicability may be long. The virus has been found in the stools for as long as three months; in the pharyngeal discharges for a much shorter period measurable in days. The incubation period is apparently somewhere between three and twenty days, with an average of five to seven days. With facts, such as these at hand, most states have promulgated regulations requiring isolation of the case and the quarantine of presumably susceptible contacts, with particular reference to children, and the restriction of activities of exposed adults who may come in contact with children or who are engaged in such occupations that may expose them to the general public.

The mode of onset of the disease varies, and

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expressions of its beginning offer such inconclusive evidence that the diagnosis is frequently not made until muscular impairment occurs, or at least until there is clinical evidence of involvement of the central nervous system.

To attempt to eliminate causative factors, presents another difficulty because of the reasons already mentioned. Good personal hygiene and general sanitation are obviously indicated. General sanitation includes the screening against such possible vectors as the common housefly. Efforts directed toward the elimination of stream pollution, which is on the program of every state department of health, may or may not play a part in the control of this disease, but is nevertheless desirable.

In the light of our present knowledge, there are two activities which can, however, be profitably engaged in by a state department of health. One relates to the coordination of emergency facilities and the other to education.

PREPAREDNESS

A state health department should avail itself of every resource in order that it may be better prepared to cope with outbreaks of unusual incidence. This means the coordination of the facilities of national organizations, such as the National Foundation for Infantile Paralysis, and the U. S. Public Health Service, as well as state and local facilities, down to the mobilization of physicians and the encouragement for the preparation of adequate treatment centers.

Preparedness in the phase of adequate treatment facilities is not only effective in allaying the fears of the general public during outbreaks, but is also essential if the afflicted individuals are to recover with a minimum degree of residual paralysis. Such planning is necessary because of the unpredictable nature of poliomyelitis and our inability to foresee accurately the occurrence of outbreaks.

We have been fortunate in Ohio inasmuch as we have not had the full blown epidemics experienced by some of the other states, yet, our lowest death rate from poliomyelitis occurred in 1945 with 29 deaths reported, and our highest in 1916 with 130 deaths recorded. So far this year only one death has been reported to the department, but we have not as yet reached the seasonal peak.

In the summer of 1945, through the state representative of the National Foundation, a Drinker respirator was placed on loan to the department to be used primarily where such equipment was not available, as in rural areas, but to be available under any circumstance where the need presented itself. This respirator is under the supervision of the department but is housed and transported by the State Department of Highways. There are 51 respirators in Ohio, two of which are owned by the Army. The remainder are in the larger cities which means that patients must be transported from the more remote rural portions of the state, if such equipment is necessary. Ohio is one of the few states to establish this emergency respirator service, which, since its inauguration, has been responsible for the saving of two lives which speaks eloquently for its value. The credit for establishing this service goes to the National Foundation through its representative in Ohio.

ADEQUATE EDUCATION

The importance of adequate education in the control of any communicable disease can not be overemphasized. The general public should be acquainted with the known facts regarding the nature of the disease, its mode of spread, its possible consequences, and means of prevention and protection. If effective cooperation is to be expected, information must be disseminated in such a manner as to give the greatest understanding to the greatest possible number of people. Unfortunately, the facts available about poliomyelitis are such that little use can be made of them by the public.

The general practice of routine cleanliness and good personal hygiene, one of the basic principles of public health, is certainly applicable to the control of poliomyelitis. Clean food, clean milk, a safe water supply, clean hands when eating, proper disposal of human excreta, adequate rest, and a balanced diet are important. Although there are some differences of opinion as to the relation of the pollution of streams with sewage to the spread of infantile paralysis, without debating this question, a state department can certainly indorse the principle of eliminating such pollution as well as the enforcement of necessary statutes or regulations to insure clean streams and safe water supplies.

MEDICAL NEEDS

Although most state health departments are not prepared to assist physicians in familiarizing themselves with the nature of the disease and its methods of treatment, it usually finds itself in a position to mobilize available resources so that this can be accomplished. Through cooperation with available schools of medicine and assisting to bring in, if necessary, expert advice from the outside, refresher courses can be conducted for physicians, nurses, and physiotherapists, and others who are essential to the general program for the control and treatment of the disease. This meeting today, in which we are cooperating with the State Chapter of the National Foundation of Infantile Paralysis, is representative of one of the roles that a state department of health can play.

General public education, as it concerns the state health department, can probably best be carried on through its Communicable Disease, Child Hygiene and Nursing Divisions, by its health educators, where such exist, and through local departments of health. The local health department in its direct dealings with people, through its nurses, for example, can do much in the educational field. Parents should be informed when information is available indicating that an epidemic may be in the making, and when such materializes should be encouraged to seek the advice of a physician immediately if their child presents symptoms which may possibly be suggestive of the onset of poliomyelitis. Although no specific and effective remedies are available, proper and early care for the poliomyelitis victim will frequently minimize the degree of crippling. The importance of early diagnosis can not be emphasized too strongly because of its relation to successful treatment.

Most state health departments are not prepared, through either staff or equipment, to undertake extensive research problems, but most departments can contribute much, particularly in the field of epidemiology. Any and all such information which can be accumulated, particularly in the instance of a disease like poliomyelitis, contributes pertinently to the sum total of knowledge. For example, several years ago a director of the Division of Communicable Diseases in the Ohio Department of Health found that by spotting the cases on a map of the state, he could show that the great majority of cases reported that year occurred along the major highways. Such information, when integrated with the total picture, is frequently of material assistance in suggesting modes of transmission. A state health department should certainly lend its support to every worth-while project that will increase our understanding of this disease.

As has already been stated, little is known regarding the actual epidemiology of poliomyelitis. The patient himself may or may not be an important source of disease dissemination. Perhaps the healthy carrier and the so-called abortive case, those which never develop paralyses, may actually represent the source of spread. In the opinion of some authorities, the disease may be as prevalent as measles, and the majority of the youth of our population becomes infected at some time early in life, and only a relatively small proportion go on to injury of the nervous system to the extent that paralyses occur. It is further theorized, that like most virus diseases, once an infection occurs a more or less permanent immunity is conferred. This thinking is in line with such facts as are known, such as the fact that the vast majority of cases occur in children under 10 years of age, and beyond the age of 40 the disease is rare.

There is little evidence to show that the closing of schools, theaters, and other places of public congregations is effective in checking an outbreak. As in the case of many of the other common communicable diseases, closing of schools when an outbreak is recognized is probably analogous to closing the barn door after the horse is gone. By the time the disease is recognized in a school population as being poliomyelitis, it is likely that exposure has already been general. It is far better to keep the children under the close scrutiny of the teacher, nurse, and school physician than to close the schools and allow them to run free on the streets. This logic has been established over and over in outbreaks of measles, scarlet fever, and other communicable diseases. Frequently, however, in spite of this logic, a local health department may be forced to recommend the closing of schools because of the pressure of an uninformed public.

SUMMARY

Although poliomyelitis has so far defeated all efforts at prevention, a good deal has been accomplished toward our understanding of the disease and its management. A feeling of futility pervades our conscience, however, because we are still attempting to put the fire out instead of preventing its occurrence. In the present state of our knowledge, we are forced to wait until actual infection occurs and then direct our efforts toward the minimizing of the disabling effects. The control of the disease is still one of the unsolved problems of preventive medicine. We have a problem which is not a matter for any individual agency, official or otherwise, but which requires the cooperative effort of every facility and agency concerned.

When we look back over the tremendous progress that has been made in the control and treatment of many diseases considered in a more or less hopeless light only a relatively few years ago, there is certainly grounds for the belief that in the not too distant future we may find the answer to the effective control of infantile paralysis.

BIBLIOGRAPHY

1. Wilson A. Smillie: Preventive Medicine and Public Health, 1945.
2. Ohio Public Health Manual, 1944.
2. James L. Wilson, M.D.: Use of Respirator, A.M.A. reprint, 1941.
4. Sewage Pollution and Poliomyelitis. A.M.A.J., Vol. 103, No. 15, April 13, 1946.
5. George Draper: Infantile Paralysis. D. Appleton Century Co., 1935.
6. News on Polio Front. A.J.P.H., February, 1946.
7. Facts and Figures about Infantile Paralysis. National Foundation, 1945.
8. Facts about Infantile Paralysis (Revised Edition). National Foundation, 1945.
9. Handbook of Communicable Diseases. Franklin H. Top, M.D., 1941.

The Progress of Research in Poliomyelitis

THOMAS FRANCIS, JR., M.D.

IN attempting to submit a report on the progress of research in poliomyelitis, it becomes apparent that all aspects of the field can not be covered thoroughly. It seems wise at this time to limit the discussion to those phases of research which deal more with the dissemination of poliomyelitis and its control. How much of this is progress depends upon the position from which one chances to view it; whether he be an individual who is attempting to progress, or the one toward whom progress is being made. In the latter instance, it may seem very slow; in the case of the former, progress is clearly seen, and the effort involved is definitely appreciated. If one were to characterize developments of the past five years it might best be done by saying that this interval has witnessed efforts to clarify the evidence concerning many of the things which have been said without substantiation, and to consolidate the position on which future advancements can be made.

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DISTRIBUTION OF VIRUS

The first of these deals with the problem of the distribution of poliomyelitis virus: Where does it reside and how does it enter and disseminate through a community? Is man the sole agency and is the disease transmitted directly from an infected person to the susceptible and how does it occur? If not, what are the instruments by which poliomyelitis virus is distributed?

For many years the bulk of opinion supported the notion that the virus of poliomyelitis was transmitted by droplet transferred through the upper respiratory tract. Virus had been recovered by a number of workers from nasopharyngeal washings of cases of the disease and in a certain number of instances from contacts of patients. Recently, however, it has become apparent that the gastro-intestinal tract furnishes a much richer source of virus and that in the intestinal excreta the virus is found in larger amounts more uniformly and for more prolonged periods than in any other material which has been studied. Nevertheless, it is still true that in the early days of the acute illness, virus can be recovered from the pharynx of a moderate percentage of cases.

WHICH ROUTE?

What is the relative importance of these two possibilities? It is important to realize that the pharynx serves as the entrance to the alimentary tract rather than being merely a part of the respiratory mechanism. The studies of Howe and Bodian, Sabin and Ward, Kessel and his associates, McClure, Faber, and Silverberg, have attempted through pathological and virus studies to ascertain the common route by which poliomyelitis virus penetrates and is distributed in the human individual. The evidence follows a rather clear pattern. Characteristic lesions have been very infrequently detected in the olfactory bulb and virus has not commonly been recovered from it or the nasal mucosa. On the other hand, it has been shown that the pharynx, esophagus, and intestines may not only yield virus but also that the lesions produced by the virus are more prominent and more common in those portions of the nervous system which supply the alimentary tract. Faber and Silverberg have but recently called attention to the involvement of the ganglia of the fifth and ninth and tenth cranial nerves and the progression of the lesion of virus injury along these channels to the nuclei of these nerves and thence to other tracts. There is clear support, then, for the idea that the pharynx may be a most favorable site for the primary penetration of poliomyelitis virus into the body. The same type of study has indicated that the intestine also can serve as the area through which the virus can penetrate and that the sympathetic fibers may be of considerable significance as a pathway of invasion. Now, if the pharynx and upper alimentary tract is, as seems to be the case, the most likely portal of entry, it is also apparent that virus reaching there from the pharyngeal secretions of an infected individual or from the lower intestinal tract might serve well to initiate the disease. Of the two, however, evidence indicates that the concentration of the virus in the stools is greater than in the pharynx; that it is more commonly found in the stools than in the pharynx; and that it remains in readily detectable amounts for much

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longer periods in the stools than in the pharyngeal secretions. It is difficult for me to believe, unless the portal of entry is markedly different from what seems to be the case at present, that the intestinal excretions are not an important vehicle through which virus can be distributed. Under these conditions various vehicles and methods for the dissemination of fecal contamination may be involved in the problem of poliomyelitis. It is true that ordinary city water supplies have not been incriminated; nevertheless, I do not believe they can be universally eliminated. Moreover, one would anticipate that improperly sanitized swimming pools might well contain virus, whether derived from the mouth or from the tail. Virus has been recovered from sewage which is an extension of the intestinal tract. Virus has been recovered from flies, presumably with human material as the source. Moreover, Ward and his associates apparently demonstrated that flies could deposit poliomyelitis virus on food in sufficient amounts to produce a carrier state in the chimpanzee. In this same species of animals, Howe and Bodian have clearly demonstrated that the disease can be produced by feeding contaminated stools.

THE ANSWER

To summarize then: It would appear that the probable route of invasion of the virus is through the alimentary tract and that up to the present the best known source of poliomyelitis virus is human excreta. That, if virus is present in the pharyngeal excretions, it can be transmitted by their transfer but apparently for a limited period by the acute case, and less commonly by the carrier. On the other hand, the clinical case as well as the non-clinical infection can, through intestinal contents, still furnish a rich source of poliomyelitis virus to the community. It would be my guess that the latter is the more significant since it is also a more persistent reservoir.

Apart from the circumstances in the individual, where is poliomyelitis virus found in the population? It has been commonly stated that by the time the incidence of paralytic cases reaches a significant level the community is thoroughly seeded and that this is a random distribution. There are reasons to believe that is not uniformly true. Several workers have demonstrated that the families in which cases of frank disease occur are likely to be permeated with virus, as measured by its presence in the stools. We have conducted several extensive studies in communities in which sporadic cases of poliomyelitis have occurred. It has been very interesting to note that the greatest frequency of virus isolations is in the familial associates of the case, both children and adults. In our studies in Fort Worth, 75 per cent of the families in which paralytic cases of poliomyelitis occurred were found to be carriers. In the families of extra-familial close associates, 18 per cent were positive. In contrast, only 1.8 per cent, or 2 of 127 families, representing 374 individuals in the same immediate area without known association with cases of the disease, was virus identified. Other studies under other circumstances are in accord with these observations. The conclusion is then that under these conditions poliomyelitis virus is not indiscriminately scattered in the population but rather that it is a group infection of intimate associates and that the paralytic cases emerge from the group as a mushroom from the bed of spawn. Moreover, the carrier state may develop in a group in a very short time as illustrated by our observation in a boys' camp where five days after the group had assembled one developed the paralytic disease, apparently brought with him; the others in his cabin had in this period become infected with the virus, as demonstrated by their positive stools. One of these developed the clinical disease 19 days later. Boys in an adjacent cabin were entirely negative. All these data lead to the conclusion that if one wishes to find the greatest nucleus of individuals actively excreting poliomyelitis virus, one will move to the family or the closely associated group in which the case appears. And, at the moment, if control measures are to be applied, that is the most practicable point at which to apply them. It does not mean that the frank case is the origin of the group infection, but that other members of the group, including adults, may bring in an occult infection and furnish it to his close associates. For this reason the tendency to drop restrictive measures or isolation precautions seems a bit premature. On the other hand, the data do not clarify the method of distribution except to indicate that close association is required except in eruptive outbreaks which suggest some common vehicle other than direct human association. Efforts to find poliomyelitis virus in other animals or biting insect in the immediate environment of the human reservoir have been, in our hands, with one possible exception, completely unsuccessful.

ANOTHER AGENT

Despite the great bulk of this evidence there remains the lurking suspicion that some agency other than the human may be an important contributor to the maintenance and spread of poliomyelitis. Perhaps the greatest influence in this thought is the seasonal prevalence of the disease in the temperate zones, its spotty distribution, and the lack of information as to how the virus persists over the winter. The season is contrary to most respiratory disease, corresponds to that of gastro-intestinal peaks but also to that at which insects and animal migration are most prevalent. The recovery of virus from

flies has already been mentioned but up to the present no other insects have been implicated. The common interpretation supported by laboratory infection of these species, is that they are but temporary vehicles which can ingest and excrete virus containing material but which do not constitute actual hosts. Nor has any other animal species but man been found to harbor typical virus. Theiler has described an encephalomyelitis of mice which bears certain resemblances to poliomyelitis in man; a disease of swine has also been noted. Jungeblut and Dahldorf have isolated viruses of that behavior from mice in nature, and we have one suggestive isolation from rats and one instance of antibodies to the Lansing strain in a rat. Thus, unless new data are obtained, we are still left with the fact that man is the major source of poliomyelitis virus.

SUMMARY

It is apparent from this general discussion that much remains to be done. There is need for a better diagnostic method than that now available and much effort is being excited to devise one. The studies of physiology of cell-virus relationship seek to determine what the type of injury is and methods of blocking it. Chemotherapeutic studies have not yet been productive. Early treatment with gamma globulin or immune serum have not yielded significant benefit. The results reported with prostigmine or curare are not preventive or curative but at best palliative. Nevertheless, investigators continue to seek methods of prevention and cure. Much publicity is given to the possible use of DDT in fly control but there is no evidence that it has any effect upon poliomyelitis. At the moment the most applicable procedure seems to be the avoidance or control of the infected human individual and his infected excreta. I have no doubt that, with the military conflict apparently past, the accentuation and support of study along the above lines and new approaches to immunity, virus identification, and the testing of different control measures will yield a solution to this serious problem.

Thymus Problem

In the differential diagnosis one must consider the following: enlarged mediastinal glands; congenital disease of the heart and great vessels; mediastinal emphysema; congenital stenosis of the larynx, trachea, or bronchi; congenital cyst of the larynx; congenital goiter; relaxed soft tissues of the pharynx and larynx; retropharyngeal abscess; meningitis; and one must not forget the effect of prolonged anesthesia during labor.—David S. Dann, M.D., Kansas City, Mo.; Jr. of the Mo. State Med. Assn., Vol. 43, No. 7, July, 1946.

Difficulties in the Diagnosis of Pinworm Infection

Anyone who has seen many children infected with pinworms is bound to be impressed by the seriousness of the condition. Occasionally children between the ages of 2 and 4 years are all but overwhelmed by the infection. While we have encountered extremely heavy infestations in children as old as 13 years, it is in the group of children under 7 years of age that the disease is most serious.

Unfortunately the diagnosis of oxyuriasis can not be made on the basis of the clinical picture alone, since any of the symptoms and signs may be caused by a number of other conditions. The most characteristic symptoms are restlessness in the sleep and poor appetite. The restlessness at night is characterized by kicking about in bed and talking in the sleep; occasionally even sleep-walking is encountered. While the appetite is usually poor for all meals, it is characteristically poorest for breakfast. Nervousness is another frequent symptom, and nightmares are not unusual. Itching about the rectum is probably responsible for a great deal of the restlessness while sleeping, but it is not usually a very prominent symptom in the mind of the patient. On examination most patients are found to have a slight pallor, and many have dark circles under the eyes. The red blood cell count is usually lowered. Although Miller and Einhorn have questioned the relation of mild anemia to oxyuriasis, it has been my experience that the hemoglobin and red cell count usually rise without further treatment when the patient is rid of the pinworms.

The feces specimen is practically useless in making the diagnosis. The most convenient method for the diagnosis of pinworm infection is the cellophane swab. In a series of more than 2,000 school children from whom both a cellophane swab specimen and a feces specimen were obtained, approximately 50 positive cellophane swabs were found for every positive stool. In only one instance was the feces specimen positive when the cellophane swab was negative. This specimen was obtained from a first-grade child, and the swab undoubtedly was not properly used.

When the infection is very heavy the cellophane swab method is quite satisfactory, and even a single swab will be positive in a high proportion of the cases. When the infection is rather light, however, even this method of diagnosis is unreliable.—Wilfred N. Sisk, M.D., Kalamazoo, Mich.; N. C. Med. Jr., Vol. 7, No. 6, June, 1946.

Spontaneous Occlusion External Iliac Artery: A Case Report

ALBERT R. SMITH, M.D., and WARREN G. HARDING, II, M.D.

SPONTANEOUS occlusion of a primary branch of the aorta is of rare occurrence. Perusal of the recent literature has failed to disclose a case in which such an occlusion has not followed operative trauma or other intra-abdominal disease. Because of the absence of any known trauma the following case is considered of sufficient interest to merit reporting in the literature.

CASE REPORT

The patient, RK, is a 26-year old white male, first seen on May 10, 1944.

Three years before coming under observation he had noted the rapid onset of pain in the calf of the left leg. This was of a steady aching character but was made worse by exercise of the extremity. At this time he also noted that the left leg below the knee would become numb and would tingle after drinking a bottle of beer, which was his custom on completion of the day's work. The numbness would subside two or three hours after ingestion of the beverage. He discontinued this habit and the numbness was completely relieved but the pain in the leg persisted. At the onset the attacks of numbness were related only to drinking beer.

The pain on exertion has steadily progressed. Over the past 6 to 10 months, Mr. K has noted shrinkage of the left calf and thigh.

At the present time (5-10-44), Mr. K gets a cramping, stabbing pain in the popliteal space on the left after walking one block. A two to three-minute rest enables him to walk again for a block. The intermittent claudication is relieved only in the standing position during this rest period. The pain persists if he sits down. When he lies down the patient has noted that the entire leg gets "white as marble" below the knee. It also gets cold and the foot tingles. He complains further of cramping of the toes.

Past History: The patient had had the usual childhood diseases. The past history was otherwise without significance. He had had no operations and no injuries.

Habits: He uses one pack of cigarettes per day.

Physical Examination: The general physical examination is negative. The salient findings are entirely limited to the left lower extremity.

Lower Extremities: There was marked atrophy of the thigh and calf. Circumference of the thigh was 16 inches on the right and 14½ on the left. Circumference of the calf was 13 inches on the right and 12 inches on the left. Motion at all joints was normal. There were no complete muscle palsies. The strength of the musculature was excellent, in spite of the atrophy. The left foot had a marble cadaverish color as this man was lying supine. We were able to produce the intermittent claudication by having him dorsi and plantar flex the foot several times. This stabbing pain was produced in about one minute of such exercise. There was some hyperhydrosis of the foot. The foot and the lower two-thirds of the calf were extremely cold.

There was no palpable pulse in either dorsalis pedis, posterior tibial arteries, nor was there a pulsation in the popliteal space or in the femoral artery at Pupart's ligament. Elevation of the extremity accentuated the marble white color of the foot and lower leg.

When the patient stood after elevation of the extremity, the foot would become fiery red and Mr. K complained of a burning sensation and tingling throughout the foot. This fiery red color would fade somewhat after two or three minutes of standing. The reflexes were physiologic.

Laboratory Data: Blood Count—H.B., 89 per cent; R.B.C., 4,570,000; W.B.C., 9,800. Urinalysis—Character, clear; Reaction, acid; Sp. Gr., 1023; Albumin, 10 mgm.; Sugar, negative; Epith. Cells, few; Bacteria, few. Wassermann, negative.

X-rays of the lumbar spine, pelvis and hips showed no evidence of bony disease or injury. Intravenous pyelograms gave normal findings as did a barium enema and G. I. studies.

Studies of the circulation of the lower extremities are as follows:

Skin Temperatures:

Left	
Upper leg	32.5 deg. C.
Lower leg	31.5
Dorsum foot	30.4
Great toe	27.5
Great toe after heat application	27.9

Right	
Upper leg	32.5 deg. C.
Lower leg	32.
Dorsum foot	32.3
Great toe	30.7
Great toe after heat application	32.

The oscillometric findings were as follows:

Index—popliteal	0	4	at 100 mm.
tibial	0	4	at 80 mm.
tibial after heat to trunk	0	5.5	at 90 mm.

Course: The fact that there was no increase in either skin temperature or oscillometric read-

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ings after vasodilator stimulation showed rather definitely that we were not dealing with a vasospastic problem. It was felt that this man had an occlusion of the upper femoral artery due very likely to external compression. There was definitely no hernia present but the inguinal ring was somewhat relaxed and did transmit an impulse on cough. On June 3, 1944, an exploration of the left lower quadrant was done (by Warren G. Harding, M.D.). The external iliac artery was cord-like and there was no pulsation in it below the bifurcation of the common iliac. The vascular sheath was normally movable and we could find no evidence of external compression. The internal iliac had a full and bounding pulse. The patient's postoperative course was uneventful and he was discharged and sutures were removed on June 14, 1944. There was no improvement whatever, of course, in the extremity.

We lost sight of the patient following this for a period of four months. When he reported back in August, 1944, he informed us that he had been receiving Pavex therapy and subjectively he felt somewhat better. The examination of the extremity showed no change and a repetition of the peripheral vascular studies showed no change whatever. We did not again see this man until August 28, 1945. Over this interval he had continued with Pavex therapy but had received no benefit and the exercise tolerance of the extremity was decreasing. There was no change in the physical findings.

SUMMARY

The case of spontaneous occlusion of the external iliac artery is reported.

Thrush as Sequel to Penicillin Treatment

Among many cases of various infections that I have treated with penicillin in recent months, reaction to the drug occurred in six cases. The mildest case was an aphthous stomatitis with oral penicillin; the severest, a generalized giant urticaria and angioneurotic edema of the face, hands, and feet, following parenteral administration of the sixth dose of 20,000 units in a case of upper respiratory infection. The other four cases suffered the painful experiences associated with thrush.

All the cases are of certain interest because of the therapeutic suggestions which proved beneficial.

The state of nutrition of the afflicted patients was good because of well-controlled, balanced diet. Whether the long-lasting fever in the two pneumonia cases was the contributing factor, or incidental contamination in the penicillin itself, would have to be verified by further observation from other sources and the bacteriologic findings as to parallel growth of penicillium notatum and oidium albicans.

The treatment consisted in painting the areas with 1 per cent gentian violet and irrigations of the mouth and throat with alkaline gargle (2 per cent sodium carbonate).—Eugene E. Marcovicci, M.D., New York, N.Y.; N.Y. State Jr. of Medicine, Vol. 46, No. 12, June 15, 1946.

Recurrent Headaches

Psychosomatic.—Many headaches are physiologically bound to the patient's vegetative nervous system, emotions, and personality. This does not necessarily mean that they are "neurotic". Chronic states of emotion have a great deal to do with smooth and striated muscle tonus, vascular tonus and secretory activity throughout the head and neck.

Some people express grief, anger, and so on differently and are not necessarily neurotic. Emotional changes may overflow into certain vegetative circuits and be manifest in disguise because the sensations then appear referable to a certain organ or system. Many patients can describe how unwept tears of sadness or anger cause pain around the eyes, temples, or maxillary region.

The management of headaches often calls for a knowledge of "the physiology of people". It is often as important to evaluate a mother-in-law at home as it is to ponder over some cervical arthritis. It may be as important to know that a patient is unusually sensitive or perfectionistic or full of medical misconception as it is to know that he has a slight hypertension.

As with a great number of other conditions in medicine, it is as important to know the host and his reactions as it is his disease. We can not be limited to inquiry concerning: What is the headache that this patient has? We must know: Who is the patient who has the headache? What is **his tolerance** to emotional strain? What is **his reaction** to it? Generalizations are of no help. All heart conditions are not myocarditis. All non-organic headaches are not migraine or psychoneurosis.

These are cases wherein a patient must be surveyed not as an isolated cerebral-vascular preparation, but rather as a **whole** and individual physiology. Muncie put it well when he reminded us that man is not a mere sum total of organs and systems, but is an integrate, not fully understandable or predictable from the anatomical and physiological data of the parts as such. Many physiological processes are long circuited by means of delayed reflexes through a wealth of experience and associated material of the individual. The patient himself is often interposed in the many reflex arcs which govern a great deal of his physiology. The origin of many headaches then is based on a highly individual physiology and pathology.—Capt. John A. Aita, MC, AUS, Galesburg, Ill.; Minn. Med., Vol. 29, No. 6, June, 1946.

Ruptured Congenital Aneurysm of the Sinus of Valsalva With Superimposed Endocarditis with Rupture of Aortic Cusp Producing Sudden Death

THOMAS L. RAMSEY, M.D., and VINCENT T. MOSQUERA, M.D.

CONGENITAL aneurysm of the aortic sinus of Valsalva is a rare entity. Very few cases have been reported in the literature as far as we know from 1899 up to the present time. In some of the cases, the aneurysm had ruptured establishing a communication with the right heart, sometimes opening into the auricle and occasionally in the ventricle.

Communication between the aorta and the right ventricle has been reported, sometimes due to acute suppurative endocarditis superimposed upon a congenital aorticoventricular fistula.

Jacobi and Heinrich in 1933 reported such a case.[1] In their report these authors cited three other cases of congenital communication between the aorta and the right ventricle. These cases had been reported by Rickards,[2] Charteris,[3] and Levingston.[4] Abbott[5] reported a case of ruptured aneurysm of the right anterior aortic sinus of Valsalva. Goehring[6] reported a congenital aneurysm of the aortic sinus of Valsalva.

CASE REPORT

The case we are reporting presents a similar pathology to the one reported by Abbott. We think this a case of congenital aneurysm of the aortic sinus of Valsalva with subsequent rupture producing communication into the right ventricle. The rupture apparently had occurred a sufficient time before the patient expired to produce changes in the ring of the orifice communicating to the right ventricle and to show signs of a regenerative process. The opening into the ventricle occurred just below the medial segment of the tricuspid valve in an area near the interventricular septum. The aortic cusps showed nodular thickenings and vegetation-like structures, particularly involving the anterior segment, this was torn and showed some clotted blood adherent to the remains of the leaflet. Miscroscopic examination revealed a subacute endocarditis.

Clinical History: This six-year old female child was in apparently good health in her first five years of life. Past history revealed that the child had several attacks of tonsilitis and two attacks of acute otitis media for which a paracentesis was done.

In April, 1943, a loud murmur was heard over the upper chest which was more accentuated over the cardiac base area. However, the child appeared in good health, no cyanosis was present, no dyspnea, the cardiac rate was within normal limits, and there were no clinical signs of decompensation. A congenital heart lesion was suspected at that time and subsequent activities were somewhat curtailed.

On September 17, 1945, the patient had an elevated temperature in the evening and vomited repeatedly. At that time blood count revealed 25,000 WBC with 90 per cent polymorphonuclears. At that time, she was admitted to this hospital and two blood cultures were taken 12 hours apart and a diagnosis of subacute bacterial endocarditis was considered. Blood cultures revealed a growth of non-hemolytic streptococci after two days, for the first culture and 14 days for the second culture. However, the second culture also revealed diphtheroids which might speak for a contamination. Within a period of 28 days, 1,400,000 units of penicillin intramuscular, 6,000,000 units Delacillin intramuscular, and 1,700,000 units of sodium penicillin orally were administered.

During the febrile period, it was noted that the heart rate was tremendously out of proportion to the temperature. One rate of 160 at rest was recorded with temperature 99.4 degrees, oral. No cyanosis was noted but hyperpnea was present practically continuously.

After this time the child was kept in bed for eight to nine weeks. Although she was afebrile she lost 12 lbs. and her heart rate at rest was usually 136. Tonics and vitamins were used without any effect for her secondary anemia. On May 1, the child was taken to a movie and didn't show any signs of cardiac decompensation. However, the following morning she was found dead in her bed.

AUTOPSY

The body was that of a well-developed, well-nourished, six-year old white female child measuring 112.5 cm. in length. The most important pathologic findings were in the heart.

The heart weighed 230 gms. The organ was enlarged due to eccentric hypertrophy of the left ventricle and concentric hypertrophy of the right ventricle. The left auricle was slightly distended. The mitral valve showed a nodular thickening of the free edge with some shortening of the ring. The valve ostium measured 6 cm. The ventricular wall measured 14 mm. in thickness near the base. The left papillary muscles were hypertrophied. The left ventricular cavity contained a large amount of clotted blood. The right auricle was markedly distended and filled with clotted blood. The tricuspid ostium showed the same nodular thickening as seen in the mitral valve. This ostium measured 8 cm. The right ventricular wall measured 10 mm. in thickness near the base. The pulmonary artery showed no abnormalities, the ostium

Selected by Thomas L. Ramsey, M.D., Department of Pathology, St. Vincent's Hospital, Toledo, as the second of a series of cases being published under the heading of "Case Records Presenting Clinical Problems".

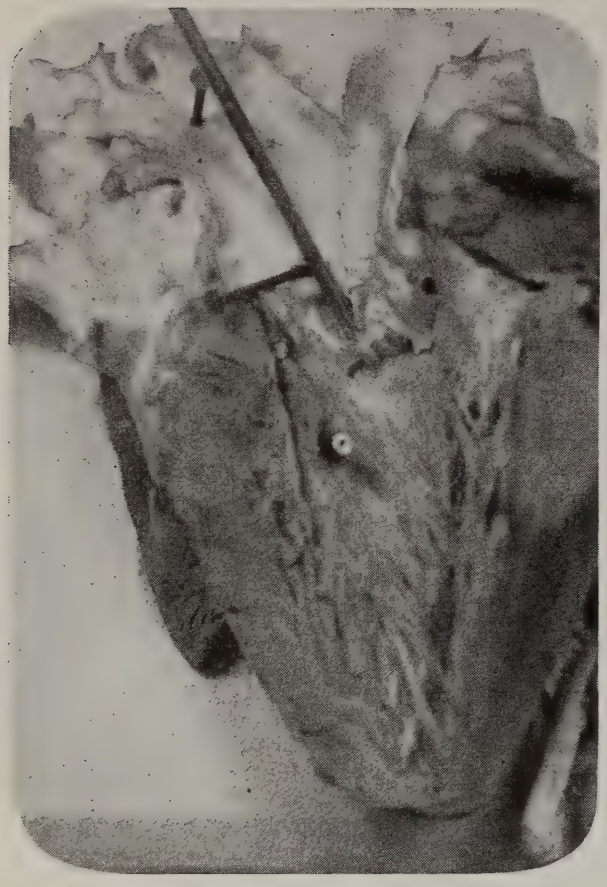


Fig. I. Left side heart. Long probe entering ruptured aneurysm behind torn right anterior cusp. A nail is placed showing opening of the right coronary artery just above the lower end of the long probe. Note also thickening of left ventricular wall.

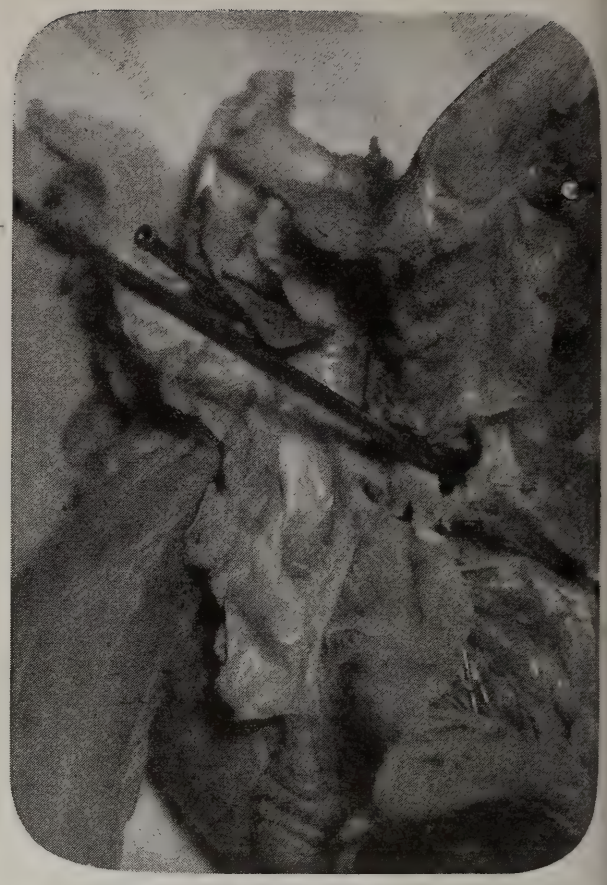


Fig. II. Right side of heart. Shows probe in rupture opening in right ventricle just below medial segment of the tricuspid valve. Chordae tendinae seen at lower right.

measured 6 cm. The foramen ovale was closed. The aortic ostium measured 4 cm. The aortic cusps showed thickening and vegetation-like structures. The anterior segment was torn and clotted blood was seen attached to what remains of the leaflet.

The coronary arteries had the normal origin, the left arising from the posterior sinus giving off the anterior descending and circumflex branches in the usual way. The right coronary artery arose from the right anterior sinus. Just below this ostium the sinus showed an aneurysmal dilatation which had ruptured and communicated with the right ventricle. The dustus arteriosus was closed. Figures I and II.

Microscopic Examination of Tissues: Section taken from the aortic cusp which was torn showed thickening of the valve with dense fibrous tissue and some edema. There was necrosis present with a fibrino-leukocyte infiltration. Polymorphonuclear leucocytes were predominant. No bacterial clumps were found.

Section from the aorticoventricular communication showed an orifice lined with a single layer of endothelial cells. There were areas of dense fibrous connective tissue and scattered round cell infiltration, particularly around the smaller vessels.

Section from the tricuspid valve showed thickening of the edge of the valve and some increased fibrous stroma. A portion of the underlying myocardium showed round cell infiltration and occasional polymorphonuclear leucocytes. There was some edema. No Aschoff's bodies were found. No bacterial clumps were present.

Microscopic examination of the other organs revealed no important pathology except for acute congestion of the liver, spleen, lungs, adrenals, and pancreas. The lungs showed many pigmented macrophages, so-called heart failure cells.

DISCUSSION

From the previous history, the necropsy and the histological findings we conclude that this six-year old female child apparently had a congenital aneurysm of the sinus of Valsalva with subsequent rupture probably occurring some time previously and may have been the explanation for the murmur heard over the base of the precordium.

A year ago this patient was treated for what it was thought to be a subacute bacterial endocarditis. Possibly the penicillin treatment altered the clinical picture and the organisms were destroyed. The sequelae are evidenced by the persistency of the vegetations with absence of bacteria.

This child was found dead in bed after having pursued her usual activities the previous evening. This sudden death probably was due to a final rupture of the aortic valve segment with subsequent acute heart failure. Cases have

been reported of such occurrence. Forbus[7] mentioned in his book, *Reaction to Injury* such a condition.

SUMMARY

A case is presented of "Congenital Aneurysm of the Sinus of Valsalva" which ruptured into the right ventricle, with superimposed bacterial(?) or rheumatic endocarditis and with subsequent rupture of the anterior aortic valve segment producing a sudden death due to actue heart failure.

BIBLIOGRAPHY

1. Mendell, Jacobi, M.D., and Abraham, Heinrich, M.D.: Congenital Aorticoventricular Fistule with Engrafted Acute Suppurative Endocarditis. Am. Jr. of Med. Science, Vol. 186, pages 364-372, July-Dec., 1933.
2. Richards, E.: Brit. Med. J., Vol. 2, page 71, 1881.
3. Charteris, M.: Med. Press and Cir., Vol. 35, page 354, 1883.
4. Levingston, B.: N. Y. Med. Rec., Vol. 24, page 249, 1883.
5. Abbott, M.: Atlas of Congenital Cardiac Disease. Am Heart Assn., page 36.
6. Goehring, Carl: Congenital Aneurysm of Sinus of Valsalva. J. Med. Research, 42:49-59, 1920-21. 26 M.
7. Forbus, Wiley D., M.D., Prof. of Path. Duke University and Pathologist to Duke Hospital; Page 430. Reaction to Injury. The Williams & Wilkins Company,1943.

Oxygen Treatment for Chlorine Gas Exposures

The following equipment is utilized in our medical dispensaries: A large tank of oxygen is mounted on a light, movable carriage; attached to the tank is a Linde Oxygen Therapy Regulator (type R-85), which regulates the flow of oxygen in liters. The oxygen is passed through an attached humidifier. There is also attached a regulator for mixing air with the oxygen so that the oxygen can be given at any desired percentage. The oxygen is administered through an O. E. M. (No. 720) Oronasal mask, which has a rebreathing bag attached.

The patient is placed in bed at rest and covered with blankets. The mask is fastened to the face and a supply of oxygen is turned on in sufficient quantity to inflate the bag. The rate of flow is usually 5 or 6 liters per minute. The oxygen is started at 95 per cent oxygen and 5 per cent air. Some cases require that the oxygen be reduced to 90 per cent. The patient is told to take slow, deep breaths. In the average case coughing will cease almost immediately. After five minutes the oxygen percentage is reduced to 80 or 85. If the patient starts coughing again, the percentage of oxygen is increased to 90 per cent. The percentage of oxygen is gradually reduced, using the return of coughing as an index, until 50 per cent of oxygen is being given. If the patient has stopped coughing, the oxygen is discontinued. It usually takes from 20 to 30 minutes to carry out this treatment in the average case. These patients not infrequently will cough up two or three tablespoonfuls of clear mucous. —Thomas W. Nale, M.D., So. Charleston, W. Va.; W. Va. Med. Jr., Vol. 42, No. 7, July, 1946.

KEEPING UP WITH MEDICINE

CONSIDERATION should be given to the use of estrogenic substances in women with puritus ani.

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ANOTHER good rule in dealing with puritus ani is to remember that in the treatment, the more acute the condition, the milder should be the medication; the more chronic, the stronger the medication.

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THE most commonly encountered birth trauma is hemorrhage and edema, particularly present in the region of the head.

* * *

IT seems clear that the biologic orientation of the human organism toward integration is an essential character and function in the higher spheres of emotional and social life.

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MALNUTRITION is recognized as a major predisposing factor in tuberculosis, though statistically its influence is hard to separate from that of overcrowding, physical stress, and poverty with which it is usually associated.

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REJECTIONS by Selective Service from January 1, 1942, through June 30, 1945, for neuropsychiatric reasons totaled 1,750,000, the majority because of neurosis.

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ELDERLY persons requiring surgery are grossly ill-nourished. Attention must be paid to the protein needs of such patients.

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THE "relaxation" headaches, such as the Sunday-morning headache of the business man, the day-off headache of the nurse, and the post-examination headache of the medical student, appear to be causally associated with relaxation of peripheral vascular tissues.

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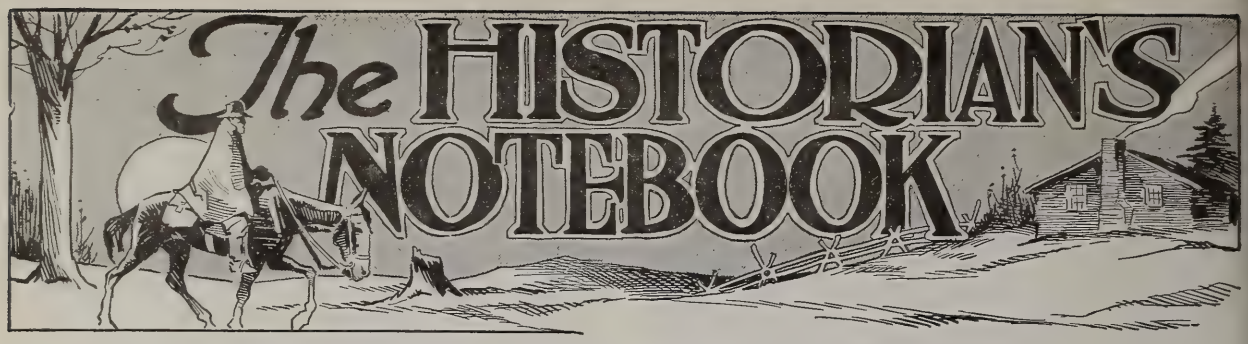
THE specific immune substances undoubtedly are related to cholinergic nerves both of sympathetic and parasympathetic origin which respond to cholinergic (parasympathetic) stimuli according to a common mode. More attention to these factors should be given in so-called intrinsic asthma.

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DERMATITIS medicamentosa is a variety of dermatitis venenata. There are more than 200 drugs in common use which may sensitize the skin.

* * *

THE phenomenon of senescence appears explainable by postulating accumulation of a toxic product of metabolism. Need this be anything other than the products of incomplete combustion of our normal foodstuffs?—J. F.



Kept by David A. Tucker, Jr., M.D., Cincinnati, Ohio

An Introductory Lecture Delivered at the Opening of

THE THIRTY-SECOND SESSION OF MEDICAL COLLEGE OF OHIO October 15, 1851

R. D. MUSSEY, M.D.
Professor of Surgery in the Medical College of Ohio

IF we turn back the annals of surgery to a period two and a half or three centuries ago, we find evidence of a state of things far different from what now exists. At that time the sympathetic treatment of wounds had acquired great celebrity in England. Sir Kenelon Digby, in his travels on the continent of Europe, learned the composition of what was called the sympathetic powder, most sovereign in the treatment of recent wounds. This remedy was applied, not to the wound itself, but to the instrument that inflicted it. So wonderful were the cures wrought in this way, that a distinguished English surgeon of that time, expresses his astonishment at its efficacy, and admits that there could be no gainsaying its power in relieving the pain of a recent wound and in promoting the healing process, but is at a loss to explain the fact, considering that the medicament was not brought in contact with the injured part, nor indeed was it necessary that it should come near to it. At the present day we can give the explanation. Faith in a vaunted mode of treatment aids in soothing pain; and the powers of nature, as strong then as now, will heal a wound sooner with the mind easy and full of expectation, than when depressed with doubt and forboding.

About the same period, surgery, in France, had gained considerable distinction. Ambrose Parey was the leading man. He availed himself of the anatomical labors of Berenger de Carpi, of Fallopius, of Eustachius, of Jean de Vigo, and Franco, and gave an important impulse to this department of the profession. He was a writer as well as a practical man, and made a large book which contains most of the valuable information then current with the profession. The following is extracted from his treatment of gunshot wounds.

"Wherefore, when you suspect putrefaction, letting alone suppurations, use, in the first place, such things as restrict putrefaction, as this following oyntment:

"Take of powdered alum, verdigris, Roman vitriol, honey flavored with roses, of each two ounces; good vinegar, quantum sufficit; boil all together secundum artem, and make a medicament of the consistence of honey." (This is the famous mel Egyptiacum.) "This", continues Parey, "by reason of the heat and subtilty of the substance, hath a faculty to induce and attenuate the humors, as also to call forth the native heat drawn in and dissipated by the violent and forcible entrance of the bullet into the body; furthermore, also, it corrects the venomous contagion of the virulent humor. Now this medicine shall be used dissolved in vinegar, or aqua vitae, and be put into the wound with tents or plegets. The tents which shall be used at the first dressing must be somewhat long and thick, that, by dilating the wound, they may make way for the application of other remedies; otherwise, you may make injection with a syringe, that so it may penetrate more powerfully. But this Egyptiacum shall be tempered according to the condition of the affected parts, for the nervous

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Reuben D. Mussey (1780-1866); M. B., Dartmouth, 1805; M. D., Pennsylvania, 1809; professor at Dartmouth and the College of Physicians and Surgeons, Fairfield, N. Y.; professor of surgery at the Medical College of Ohio, 1838-1851; professor of surgery at Miami Medical College, 1852-1857; President of the American Medical Association, 1850.

Mussey was for many years a leading surgeon in the Middlewest, known as a bold but careful operator: antedated Marion Sims in the successful surgical treatment of vesicovaginal fistula.

Edited by David A. Tucker, Jr., M.D., asst. dean, and professor of medical history, University of Cincinnati.

parts will be offended with it as being too acrid; but it may be qualified by admixture of the oyl of turpentine and St. John's wort; also, we may well be without the Egyptiacum, when there is no such pestilent constitution of the air as was seen in the late civil wars. After the use of Egyptiacum, you shall, with emolient or lenitive medicines, procure the falling away of the eschar, and such a medicine is this following oyl, being somewhat more than warm.

"Take of oyl, in which violets have been steeped, four pounds; put into this two newly born puppies, and cook them even to the dissolution of the bones, and then add a pound of earth worms fitly prepared, simmer them together over a gentle fire, and after straining them, add three ounces of Venice turpentine and an ounce of brandy. This oyl hath a wonderful force to assuage pain, to bring the wound to suppuration, and cause the falling away of the eschar. Put, of this, a sufficient quantity into the wound; for this being applied indifferent hot, hath power to assuage pain, to soften and humect the orifice of the wound, and help forward suppuration, which is the true manner of curing these kinds of wounds, according to the rule of Hippocrates, which wishes every contused wound to be presently brought to suppuration, for so it will be less subject to a phlegmon; and besides, all the rent and bruised flesh must putrifie, dissolve and turn to quitture, that new and good flesh may be generated instead thereof."

This account of the dressings employed in the time of Parey, exhibits a striking contrast with the simpler and safer measures practiced at the present day. That so disgusting a composition, as the last described "oyl", should have been tolerated within the limits of the regular profession, sufficiently marks the obscurity which rested upon the minds of distinguished men in relation to physiology and disease. Ambrose Parey was a great man and an eminent surgeon, and, by the translation of his writings into English, exerted an influence beyond the limits of his own country. So highly did the French king, Charles IX, value his talents, that, on the night of the festival of St. Bartholomew, when the massacre of seventy thousand Protestants began under his secret order, he shut up Parey in his own closet, and thus saved him from the general slaughter.

According to Richerand, "the collection of the Memoirs and Prizes of the Royal Academy of Surgery", instituted in 1731, "comprises the history of a glorious epoch of our art. There are registered the works of I. L. Petit, of Ledran, of Garengeot, of Lafaye, of Verdier, of Foubert, of Hevin, of Fabre, of Lecat, of Puzos, of Bordenave, of Sabatier, whose reputation rests also upon other works; and of many other practitioners who less illustrious, have yet, by the union of their efforts and their knowledge, helped to build up this honorable monument. To the list of names justly famous, must be added those of Lamothe, Maitre jean, Goulard, Daviel, Mejean, Pouteau, David and Frere Cosme. The lustre which distinguished French surgery became a worthy subject of emulation for the rest of Europe. In these times, lived, in England, Cheselden, Douglass, the two Monroes, Sharp, Cowper, Alanson, Percival, Pott, Hawkins, Smellie, and the two Hunters; in Italy, Molinelli, Bertrandi, Moscati; in Holld, Albinus, Deventer, Camper; in Germany and the North of Europe, Heister, Platner, Stein, Roederer, Bilquer, Acrell Callison, Brambilla, Theden and Richter. All these celebrated men were accustomed to regard the Academy of Surgery as the centre of learning, from which, all departments of the art received illumination. The superiority of French surgery was generally recognized, and nobly avowed by the greater proportion among them."

The labors of John Hunter form an epoch in surgery; and since his time, inventions and improvements have increased, so that not a year now passes without valuable additions to the stock of surgical knowledge. The inductive philosophy has become the pole-star of pursuit; and under its auspices our science has had a movement, never at intervals retarded, but in a ratio, from period to period, uniformly accelerated.

* * *

In gunshot wounds, the treatment has been improved by introducing water dressings, and still further by the wet bandage of Dudley. These injuries, when in the limbs and confined to the soft parts, have been repeatedly cured without suppuration.

Certain poisoned wounds: the bite of the rattlesnake, it is alleged on pretty good authority, has been cured by the early local application of the tincture of iodine.

Tetanus (traumatic) : a number of well authenticated cases have been successfully treated by chloroform.

Erysipelas: locally iodine, nitrate of silver; internally, carbonate of ammonia, opium and quinine. In phlegmoid erysipelas, as well as carbuncle, incisions are of great value.

Anaesthetic agents: a priceless boon, recently handed down to us by a kind Providence to disarm surgery of its terrors. In my practice ether and chloroform have been used, without injury, in over six hundred operations. In St. Bartholomew's Hospital, in London, according to Mr. Skey, in a statement made last summer, chloroform had been employed, without injury, in between nine thousand and ten thousand operations. The French academy awarded for this discovery, to our countrymen, Doctors Jackson and Morton, each a medal; the one for having

made the suggestion, the other for having put the suggestion to experiment.

In surgical anatomy, great progress has been made. This is exemplified in the anatomy of the neck, in reference to the extraction of tumors and the ligating of vessels. The anatomy of hernia has arrived at wonderful precision, compared with what was known a century ago. Various accompaniments of strangulated hernia—difficulties to be encountered, and means of meeting them—are far more clearly understood.

Surgery of the Arteries. This department has undergone such important modern improvements, as almost to admit of its origin being dated about the time of Hunter. Ligating an artery on the cardiac side of an aneurismal tumor has been chiefly practiced. The artery, too, has been successfully ligated on the distal side of the tumor, as recommended by Brasdor. Success, too, has repeatedly followed the compression of the artery on the cardiac side of the tumor; and even on the distal side, as reported by Dr. Goldsmith, of Vermont. In a recent aneurism, according to Dr. Dudley, a compress upon the tumor, supported by a bandage upon the whole limb, has effected a cure.

In 1845, the subclavian artery had been ligated sixty-nine times: of this number there were thirty-six recoveries and thirty-three deaths.

Dupuytren and Liston, each, has tied successfully the subclavian artery, under cover of the anterior scalenus muscle.

The aorta has been ligated four times, the arteria innominata nine times, and the subclavian, on the tracheal side of the scaleni muscle, five times. Death followed in every case, leaving surgeons little room to hope for any better result from a repetition of either of these operations.

The surgery of the eye has been greatly improved by Scarpa, Maunoir, Adams, Lawrence, Mackenzie, Tyrrel, Alexander, Roux, Velpeau, Sichel, Desmarses, Cuvier, Rogers, Delafield, Pancoast, Hays, and a host of others

In the surgery of the ear, Itard, Deleau and Kramer, have been distinguished.

Plastic surgery has undergone important modern improvements. Taliacotius, of Bologna, in Italy, in the latter part of the sixteenth century, gained a temporary celebrity by his rhinoplastic operations, in which he formed a new nose by a flap of skin taken from the arm. This operation fell into disuse, for a long period. Rhinoplasty, however, was revived and improved by Messrs. Carpue and Linn, of London. More recently, plastic surgery attracted the attention of numerous surgeons, as Graefe, Diefenbach, Frick, Zeis, Chelius, Delpech, Dupuytren, Lisfanc, Jobert, Liston, J. M. Warren, Pancoast, Mutter, Post and Hullihen.

Staphyloraphy or palate suture was practiced with success by Roux, Graefe, Diefenbach, Warren, and others. This operation has been recently improved by Mr. Ferguson, of London, by dividing the levator palati and palato pharyngeal muscles.

In harelip operations, important improvement has been made, especially in those revolting cases with a double fissure and a peninsular portion of the upper jaw connected with the septum of the nostrils, and projecting horizontally forward.

Tenotomy and myotomy: great progress has been made in the relief of deformities, as of club-foot, wry neck, strabismus, permanently contracted fingers.

In chronic enlargement of the tonsils, excision is now employed instead of ligation, which was used forty years ago.

Cancer of the tongue: nearly half of that organ has been successfully removed.

Excision of the upper and lower jaw: the latter operation has been performed by disarticulating the bone without dividing the facial nerve or the duct of Steno, thus preserving the symmetry of the face.

In chronic abscess of bone, limbs are now saved by perforating the wall of the bone, which were formerly doomed to amputation.

In fractures of the limbs, the wet bandage of Dudley, in addition to splints, should not be overlooked, as marking improvement in the treatment.

In compound fractures, the collodion is of great value in excluding the air from the wound. In un-united fracture, or false joint, the seton, sawing the ends of the bones, subcutaneous scarification, lateral or longitudinal compression of the fragments, ivory pegs and wire bridles, and more especially a suitable constitutional treatment, have, in their turn, promoted cure.

In dislocations, anaesthetic agents will probably take the place of copious bleedings, nauseating doses and the extreme warm bath.

In amputations, the flap operation, as well as amputations at the hip, shoulder and ankle joints, show a progress in this department of surgery.

Diseases of the joints are better understood than formerly, and the treatment is more successful. Excision of the diseased elbow joint has been repeatedly successful.

Iodine injections in hydrarthus, in enlarged bursae, mucosae, in ganglions, in spina bifida and chronic hydrocephalus, have been practices with important benefit.

Injuries and diseases of the brain and spinal cord are much better understood.

A well-known and wide-spread contagious disease: the whole subject revolutionized within the last twenty-five years, by Ricord.

Great improvement in the treatment of fistulous communications between mucous canals and cavities, as well as strictures of mucous canals, varicocele, and spermatorrhoea.

The removal of vesical calculus by lithotripsy, and especially by the operation of bilateral lithotomy, is regarded as marking a progress in this department of surgery. This last operation is probably destined to take the place of all others in lithotomy.

Ovarian tumors treated by operation with important success, on the whole. More than two hundred and twenty cases, in all, are on record, most of them within the last half century. Excision of intro-uterine fibrous tumors per vias naturales: four cases out of five successful, by our countryman, Prof. Washington L. Atlee.

Anatomy lies at the foundation of all that is safe and valuable in operative surgery.

I once saw a gentleman dissect out a small tumor that lay over the ramus of the lower jaw. He was not aware of the position of the facial nerve. After the tumor was removed, a segment of that nerve, half an inch in length, lay loosely attached to the back part of it. This nerve might as well as not have remained untouched, and its important function to the muscles of expression, upon one half the face, preserved. The patient was a handsome young lady—but the symmetry of the face was marred, the mouth distorted and the beauty gone. So much for bad surgery.

The same surgeon, on another occasion, undertook to remove an enlarged thyroid gland. The patient, a girl of thirteen or fourteen years, whose general health was not at all impaired by the chronic local enlargement, was assured by the doctor that he could give her as small and smooth a neck as other young ladies had. She submitted to the operation. The bleeding was so profuse that the surgeon desisted before the tumor was half dissected out, and death followed in a few hours. He seemed not to know that the thyroid arteries, especially the inferior, are very difficult of access for the ligature.

An acquaintance with physiology is of great importance in surgery, both to aid in the decision of the question of a contemplated operation, and to guide in the prognosis.

We have known an operator who dissected out a tumor from the abdomen, mistook it for the liver and reported the next day that the liver was out, and the patient doing well. It would require but a superficial knowledge of the circulation of the blood to prevent such a mistake as this. How could a patient be expected to live half an hour without vessels to carry back to the heart the great mass of blood thrown out by the coeliac and mesenteric arteries?

To the safe surgeon, however, a fuller acquaintance with physiology is necessary, than that which refers to the route of the blood in its movements to and from the heart. The mutual relations of the great primary functions, as far as they can be known, should be understood. In estimating the probable results of a grave operation, the state of the respiration, of the circulation, of the nervous system, of the alimentive apparatus, as well as the secerning organs, especially the liver and kidneys, should be taken into the account. Serious consequences are liable to follow a severe operation under an irritable and diseased state of the nervous system. Hence, those who have indulged freely in the use of intoxicating drinks are bad subjects for operations. Even a very trifling operation under these circumstances is sometimes sufficient to throw the whole machinery of life out of gear, and to cause speedy death.

I have known the removal, by dissection, of a tumor not much larger than a hen's egg, from a patient habitually intemperate, followed by death in four or five days—no preparation of his system having been made for the operation.

When the kidneys are diseased, yielding a particular, unnatural secretion, the operation of lithotomy is almost sure to shorten life.

Who would now undertake a severe operation, with great confidence of success, upon a patient laboring under an attack of asthma or under great irregularity of pulse, from valvular disease of the heart, conjoined with hydrothorax?

What should be expected from an operation involving the deeper sympathies of the organs, when the lungs are extensively diseased, and the whole system wasted and weakened by a consuming hectic? I knew an operator who undertook the removal of a scirrhous breast, under such circumstances. The patient died on the third day. This drew from the doctor the remark, that, had he known the patient was in a comsumption, he would not have operated. Ought he not to have known it?

Derangements in the functions of the liver, accompanied with peritoneal dropsy, should forbid a severe operation. A gentleman removed an ovarian tumor from a patient who had for some time labored under peritoneal dropsy, as well as anasarca of the limbs; the fatal result was what ought to have been calculated upon the fullest confidence.

When the digestive organs are much in fault, those operations which require the adhesive process, or reunion by the first intention to accomplish the end, as operations for the removal of deformities from burns or ulcerations, almost constantly fail.

In preparing a patient for a grave operation, it should be the object to establish as healthy a condition as possible of the alimentive organs, and secure an equilibrium of vital movement between these and the other systems of organs already alluded to, as the nervous, the respiratory, the circulating and the glandular; but, in attempting to do this, the surgeon should not leave out of view the previous habits of the pa-

tient. If he has lived freely, and for sometime daily used stimulant drinks, it would be unsafe, perhaps disastrous, to change his diet so far as to abstract all stimulants and to substitute for them gruel and gumwater. A moderate reduction only of the stimulus is better suited to sustain the vital energies required for the operation, and the subsequent processes of reparation. There is reason to believe that some lives have been lost by too great a reduction of the diet made before an operation, and not continued long enough to familiarize the organs with the innovation and establish an equilibrium of action among them, at a different grade from what had existed for several years.

The temperature of the atmosphere is a matter of no small importance in estimating the results of a proposed severe operation. In very hot weather, all such operations should be avoided, unless the urgency of the symptoms or the nature of a casualty, calling for it, forbid the least delay.

About seven years ago, we had a few days of very hot weather, the last day the hottest, and on that day we lost, in our hospital, ten patients laboring under various maladies. One who had had a tumor removed from his neck, and was doing well, died that day.

Mr. S., from Lower Sandusky, in July, 1845, came to this city with an osteosarcoma of the upper arm bone, involving the shoulder-blade and the acromial extremity of the collarbone. He was greatly fatigued by the journey—had much pain in the arm and shoulder; and the system sympathized so strongly with the diseased part as to cause a rapid pulse and considerable disturbance of the functions. The weather was exceedingly hot.

We waited several days till there came a free rain fall, which cooled the atmosphere a number of degrees. This juncture was seized upon for the operation; the arm, the entire shoulder-blade and half the collarbone was removed.

The system, as if released from an immense load, reacted kindly, and the wound healed rapidly. In three weeks the patient returned home: and last year, that is, five years afterward, he was well.

The period is nearly gone by when important surgical operations are conducted with flourishes for display, when the operator cuts against time, to exhibit to the bystanders his extraordinary dexterity. "That operation", said Mr. Abernethy, when he saw a student take out his watch at the commencement of an operation, "that operation, let me tell you, sir, is quick enough done, that is well enough done." The enlightened and skilful and conscientious surgeon keeps in view the best interests of his patient, and while his knowledge of anatomy enables him to proceed without misgiving and irresolution, he goes through it cool and collected, carefully avoiding those parts which need not necessarily be wounded or disturbed; and whatever time is requisite to accomplish this end, he takes, as due to his patient.

I knew an operator some years ago, who undertook the removal of a scirrhous mammary gland in the presence of several professional gentlemen, among whom was a surgeon of some note from abroad. It was thought, from his movements, that he was willing to show his dexterity with the knife; and while the operation was going on with a good degree of rapidity, he let the point of his knife slip through the intercostal muscles and the pleura. He had presence of mind enough as he took the alarm by the hissing of the air as it passed into the chest, to clap his finger upon the aperture, and, in place of it, substituting the finger of an assistant, finished the operation with more caution. In dressing the wound, a portion of integument was brought over the muscular opening, and the patient was saved.

The excessive loss of blood in an operation is attended with great danger. Such precautionary measures, therefore, both at the commencement and during the progress of it, as may most effectually guard against this, should never be neglected.

A Chinese gentleman of distinction came to London for the removal of a very large tumor. A distinguished surgeon was selected for this highly responsible duty. He succeeded in dissecting out the tumor, but his patient died soon after—partly, perhaps, from the shock of the operation, but chiefly, as many professional gentlemen believed, through loss of blood from divided veins. Had that distinguished surgeon proceeded more slowly, and tied up as he went along, the bleeding veins as well as arteries, he might probably have escaped the disappointment and the deep and durable regret which must necessarily have followed; besides carrying with him, through life, the consolation of having been instrumental in restoring to his friends a member of the human family who, for years, had been shut out from the intercourse and endearments of society.

In the treatment of patients after grave operations, much depends upon the state of the atmosphere of the apartment. A comfortable temperature, rather cool than warm (if the season of the year admit of a due regulation of it), is an object; but a matter of far greater importance is the purity of the air which the patient is compelled to breathe. This can be secured only by adequate ventilation; and so ignorant, not to say perverse, are most nurses in relation to this subject, that if the professional attendant does not look to it himself, and almost daily, too, his patient will suffer, if not die, from the pernicious influence of foul air. The concentrated effuvia

issuing from the lungs and skin constitutes a poison as destructive as a pestilence; indeed, a dire pestilence has been caused in this way. The well-known destruction of life in the Black-hole of Calcutta, and the deadly fevers emanating from prisoners brought out in filth from their cells for trial at the Old Bailey, are illustrations of these remarks.

The feeding of patients after operations is another point of great importance. While they should not be fed so high as to clog or obstruct the organs, they should not be kept so low as to exhaust the vital powers from inanition. In 1830, the treatment of patients of this description in the Parisian and London hospitals was widely different. At the Hotel Dieu, all the food a patient, after a grave operation, for the first, second, and sometimes the third day, was allowed, was two tablespoonfuls of beef-tea at ten o'clock in the morning, and the same quantity at five in the evening. On the third or fourth day, if no symptoms of inflammation had appeared, an additional spoonful of this food was permitted. In St. Bartholomew's Hospital, in London, a patient was allowed as much milk porridge, with bread, as he would take on the first, second and third day; and on the fourth day, food a little stronger was given, if the patient was disposed to take it. Mark the difference in mortality. A young man who had been an interne in the Hotel Dieu, for nearly three years, assured me, that, during his residence in that establishment, more than two-thirds of the patients who had undergone amputation of the large limbs had died; while in St. Bartholomew's Hospital, as appeared from the surgical records, there was only one death in a fraction less than six cases.

Ignorance and imposture make less headway in surgery than in physic, obviously from the fact, that surgical cases with the results of treatment fall more directly under the observation of those who are not skilled in either. A dislocated joint often tells its own story correctly to the patient and his friends; and the assertion that it is put in place, when it is not, is more easily disproved than a statement that the liver is the seat of disease, and that restoration is owing to the use of a particular medicine. The patient, is ignorant both of the phenomena of internal diseases and of the powers of nature in curing various ailments, is a fit subject to be practiced upon by trick and deception.

* * *

"The difference between a surgeon and a mere operator", says our distinguished countryman, Dr. Goodman, "may be estimated by contrasting them. The surgeon inquires into the causes, and removes the consequences of constitutional or local disease; the operator inquires into the willingness of his patient to submit, and resorts to the knife. The surgeon relies on the restoration of the healthy actions by regimen and medicine; the operator relies on himself, and cuts off the diseased part. The surgeon reflecting on the comfort and feelings of his patient, uniformly endeavors to save him from pain and deformity; the operator considers his own immediate advantage, and the notoriety he may acquire, regardless of other considerations. The surgeon reluctantly decides on the employment of instruments; the operator delays no longer than to give his knife a keen edge. The surgeon is governed by the principles of the science; the operator, most generally, by the principle of interest. One is distinguished by the number he has saved from mutilation and restored to usefulness; the other by the number of cripples he has successfully made. The surgeon is an honor to his profession and a benefactor of mankind; the mere operator renders the profession odious, and is one of the greatest curses to which mankind, among their manifold miseries, are exposed."

The field of surgery is still open. Its limits can not be defined by the keen vision of the most practiced seer. Inventions and discoveries yet to be made, will doubtless save, under casualty and disease, many a patient, such as is now given over to the destroyer. But eminence, in this department of our profession, is not to be attained without exertion. That eminent surgeon, Sir Astley Cooper, often said, that whatever of distinction he had gained, was due to hard work and perseverance. An ephemeral eclat may come from a clever operation, but an enduring fame is to be earned only by untiring labor and self-denial.

Are there those within the reach of my voice this evening, who, in that magnificent temple just erected in this city, soon to be dedicated to science and humanity, shall receive an impulse which no viccissitudes in future life can abate—shall have a flame kindled in the pursuit of truth in a philanthropic profession, which nothing but death can extinguish, and whose names shall be placed by posterity upon the same roll with those of a Dupuytren, a Velpeau, a Graefe, a Dieffenbach, a Cooper, a Brodie, a Physick, a Dudley, a Mott, a Warren?

Aviation Deafness

In ascent, at the rate of 5,000 feet per minute without opening of the eustachian tube, the pressure inside the tympanum will be 3 to 5 millimeters of mercury higher than the outside at 200 feet, 10 to 15 millimeters higher than outside at 500 feet, and 15 to 30 millimeters higher than outside at 1,000 feet. Byron M. Merkel, M.D., Des Moines, Ia.; Jr. of Ia. State Med. Society, Vol. XXXVI, No. 7, July, 1946.

The Study of Child Health Services; Purposes of Ohio Project Outlined by Director of Proposed Survey

BENJAMIN HOYER, M.D., Cincinnati, Ohio

IN our democracy we accept as obvious and incontrovertible truths the rights of the child: to be well-born, well-nurtured, well-educated, and well-adjusted; that is, to be well-fitted to develop to the limit of his capacity. In providing these rights for children many factors and agencies come into play.

We physicians begin at the time of the child's conception by means of scientific prenatal care to provide him with the best possible environment. We try to see to it that his birth takes place under conditions as favorable as possible. We protect his health to the best of our ability through his formative years and strive to bring to him the finest known facilities for his education and the development and expression of his personality.

But it is evident that it takes a great deal more than conscientious medical care to produce proper physical and mental health. We have come to think more and more about the factors that make for healthy children in the past few years. We know that in addition to good medical care, also good housing, good food, a happy home life, and satisfactory educational and recreational experiences are necessary for health.

It is a fact that all parents in this country do not, for one reason or another, secure these health-building facilities for their children, or may sometime suffer economic set-backs that cripple the family's ability to provide. As physicians we know further that there are certain gaps in the medical care of children—spotty distribution of medical personnel, community health facilities, and hospitals, and there are inequalities among the various economic groups.

Dr. Warren R. Sisson, of Boston, has said, "Legislators, anticipating that the American people are becoming aware of the limitations of medical practice and desirous of better medical care, are introducing bills in both federal and state legislatures, with the hope of solving this problem. It has been felt by some in the medical profession that the initiative in this matter should be taken by the physicians. It seems fair to assume that no plan can be effective unless it has the complete understanding and support of the group which must actually provide the service."

The members of the American Academy of Pediatrics feel that if children are to be guaranteed their axiomatic rights, including the protection of their health, it is the responsibility of the physicians of the country to see that good medical care is made available. But before we can make any effective plan for improving the health of our children we must have accurate and complete knowledge of the present state of affairs in that field of medicine.

Accordingly, the Academy has embarked upon an undertaking of gigantic proportions: the gathering of information concerning the medical care which children of the United States are now receiving. Every hamlet, village, town, and city in the country will be studied to determine what health facilities each provides for its children. Every physician and every dentist up and down the land will be asked to tell how much of the burden of the medical care of young patients he is carrying and how well the public health facilities in his community meet his needs in providing care for those patients. Every hospital and every health department will be scrutinized in detail to find out how well they are providing for the needs of the community. And, finally, since provision of good medical care presupposes good medical training, every medical school in the country will be investigated by a group of physicians qualified in the field of medical education.

The Study of Child Health Services has as its objective: "To make available to all mothers and children in the U. S. A. all essential preventive, diagnostic, and curative medical services of high quality, which, used in cooperation with other

Editor's Note:

The accompanying article was prepared by Dr. Hoyer at the request of The Journal. The purpose is to give Ohio physicians a picture of the underlying reasons for the study and survey of child health facilities in Ohio which will be started in the state soon under the auspices of the Ohio branch of the American Academy of Pediatrics.

The study has the approval of The Council of the Ohio State Medical Association and the study is under the direction of Dr. Hoyer, Cincinnati pediatrician, and Dr. E. V. Turner, formerly of Ohio, who are serving as chairman and executive secretary, respectively, of the project.

services, will make this country an ideal place for children to grow into responsible citizens."

It is believed that a thorough study of existing facilities and professional personnel will reveal not only what the needs are but also where the needs are greatest, and thus provide physicians with the essential basis for intelligent and constructive planning of medical care for the future. This is a study by doctors, for doctors, that will bring to doctors the information they need to carry on their work. Thus, by examining their own affairs, the physicians of the country will secure the data necessary for plotting the course of medical care of children in America.

Legislature Enacts 18 Bills at Special Session in June

Called into special session June 24 by Governor Frank J. Lausche to consider 26 "emergency" measures, the Ohio General Assembly enacted 18 and recessed from June 29 to July 8 when it adjourned.

The Legislature made additional appropriations amounting to $14,668,989, including an increase of $5,000,000 in the state's $16,000,000 subsidy to local governments. Also included were the following:

Supplemental appropriations totaling $2,577,420 to the Welfare Department for the operation of state mental institutions.

Appropriation of $1,150,000 for improvements and repairs at the Tiffin and Youngstown state hospitals and for power plants at other institutions.

Authorization for the state to acquire Hoover Pavilion from the city of Cleveland as a receiving hospital for mental patients.

Appropriation of an additional $750,000 for poor relief for the balance of 1946.

Restoration of Civil Service rights of veterans lost while they were in the service.

Modifying of legal requirements governing the licensure of engineers, for benefit of qualified veterans.

Permission for qualified veterans to obtain licenses as pharmacists without a year's practical experience in a drug store.

Governor Lausche was requested by several returned medical officers who are graduates of foreign or unapproved medical schools, to ask the Legislature to liberalize the Medical Practice Act so as to permit them to qualify for licensure in Ohio. Despite considerable pressure, the Governor refused to include the question in his special call, until it had been considered by the State Medical Board. Before the Board had an opportunity to meet, the Legislature had concluded its four-day session.

O.S.M.A. To Exhibit at State Fair

The Century of Progress in Medicine exhibit, which was displayed at the Centennial Anniversary Meeting of the Ohio State Medical Association in May as one of the historical features of the meeting, will be shown at the Ohio State Fair, August 24-30, 1946.

The State Association will have its booth in the southeast corner of the new State Exhibit Building at the fair. Literature will be available at this booth concerning the 25-point Health Program for Ohio, as adopted by the House of Delegates at the Annual Meeting.

During the month of July, the historical exhibit was on display at the Cleveland Health Museum.

Dr. Knies On Health Council

Dr. Philip T. Knies, Columbus, assistant clinical professor of medicine at the Ohio State University College of Medicine, has been appointed by the Governor as a member of the Ohio Public Health Council for a term beginning July 1, 1946, and ending June 30, 1953.



Philip T. Knies

Dr. Knies served as Army Quarantine Liaison Officer, Preventive Medicine Service, Office of the Surgeon General, during World War II, received the Legion of Merit for his work, and was separated from service with the rank of lieutenant colonel. On the Health Council he will succeed Dr. Russel G. Means of Columbus, who declined reappointment.

Central Ohio Radiologists Meet

A dinner meeting, held June 13 at the Seneca Hotel, Columbus, was one of the first activities of the Central Ohio Radiological Society, which was organized during the Annual Meeting of the Ohio State Medical Association in May.

Active membership is open to radiological specialists living within a convenient radius of Columbus and associate membership to those not specializing in radiology, but who are interested in the subject. Dues are $10 a year for active members and $2.50 for associate members.

Officers for the current year are: Dr. Arnold D. Piatt, Newark, president; and Dr. Hugh A. Baldwin, 347 E. State Street, Columbus, secretary.

Members Totaling 3,813 Have Signed Up To Date Under Veterans Medical Care Plan; New Names Being Sent To V. A. Periodically; Ruling on Problem Asked

UP to the time this issue of *The Journal* went to press, 3,813 members of the Ohio State Medical Association had returned cards indicating a willingness to participate in the Ohio Veterans Medical Care Program and their names had been certified to the Branch Office of the Veterans Administration at Columbus as fee-designated physicians.

As rapidly as names are certified to the Branch Office, lists are sent by that office to the various regional and sub-regional offices of the Veterans Administration throughout the state.

Reports from all parts of the state indicate that the program, which became effective July 1 and which was described in detail in the July 1 issue of *The Journal*, is in operation in most areas and that veterans with service-connected disabilities now are being given an opportunity to receive out-patient care from their family doctor or some physician of their choice.

BRADLEY ASKED FOR RULING

However, a difference of opinion, or misunderstanding, on the part of some officials of the Veterans Administration, notably in the district served by the Cleveland Regional Office, has temporarily delayed operation of the free-choice-of-physician feature of the program in some communities.

Some of the Veterans Administration officials contend that the Ohio State Medical Association program is intended only to "supplement" out-patient services provided by dispensaries of the regional or sub-regional offices of the Veterans Administration. These officials have refused to authorize a veteran to receive treatment from his own physician, stating that the veteran should present himself to the V. A. dispensaries for medical care. They argue that care by physicians in private practice can not be authorized unless the V. A. dispensaries are unable to care for more patients or it would be a hardship for the veteran to report to the V. A. clinic for treatment.

Obviously, this policy is contrary to the intent and purposes of the State Association plan which is designed to permit eligible veterans to select their own physicians from among fee-designated doctors. Moreover, in the opinion of officials of the State Association, it is in conflict with the views of General Hawley, medical director of the Veterans Administration, who has encouraged the establishment of programs like that of the State Association in order to give veterans an opportunity to receive medical attention from their home-town physicians.

This important question has been submitted to General Omar N. Bradley, administrator of Veterans Affairs, for adjudication and it is hoped that a procedure will be worked out which will not nullify the operation of the Ohio program.

OFFICIALS HELPFUL

Officials of the Columbus Branch Office of the Veterans Administration have given the Committee on Medical Care of Veterans splendid cooperation in setting up the program and in getting it into operation. Frequent conferences will be held with these officials in an effort to work out any misunderstandings or complications which may arise.

Members of the State Association who have not as yet signed up for the list of fee-designated physicians may do so at any time by requesting the Columbus office of the State Association to send them a card or by sending in the card which was mailed to all members prior to July 1.

REGARDING EX-SERVICE PHYSICIANS

Discharged medical officers of World War II who are not at present members of the State Association, but who have intentions of affiliating, may have their names certified to the Veterans Administration as fee-designated physicians by having the president or secretary of the County Medical Society of the county in which they reside and practice, send a written statement to the Columbus office of the State Association to the effect that their application for membership is on file and that he (the president or secretary) approves of placing the name of the former medical officer on the certified list.

A bulletin setting forth this policy has been sent to all County Society Presidents and Secretaries. Non-members who are former World War II medical officers who have written to the Columbus office asking to be placed on the certified list have been informed of the procedure described above.

LEGION BOOSTS PLAN

Widespread publicity has been given to the State Association plan by the press of the state. Apparently veterans and veterans organizations are enthusiastic about the program. Evidence of this will be found in an editorial, signed by Harvey C. Cheney, Department Service Officer of the Ohio American Legion and published in



Reproduced From and Through the Courtesy of The Ohio American Legion News

the July 11 issue of *The Ohio American Legion News*, reading as follows:

"Collier's Magazine and the Reader's Digest have publicized the Michigan Medical Plan and what the plan is doing for the veterans of that state. Hats off to Michigan! But get ready to doff the lid for what the Ohio State Medical Association is doing in putting into effect the Ohio Plan, which should put Ohio on the right side of the ledger.

"The Ohio association tackled this job early this year. A very fine committee on Medical Care for Veterans was appointed by President Edgar P. McNamee. It was composed of top flight men in every branch of medicine, almost all of them veterans. This committee arranged a plan to fit the situation in Ohio and it has been approved by the Veterans' Administration. It became effective July first and will become of increasing importance as more and more local physicians take advantage of it.

"When General Hawley took charge of the medical branch of the Veterans' Administration, he saw at once that there was not sufficient VA hospital facilities to care for all of the ex-service men who would be entitled to treatment for service-connected disabilities. The next alternative was to look to the local medical men. To these groups, General Hawley presented his request that they lend assistance and work out a plan suitable to the group in each state. It was in response to this request that the Ohio plan was devised.

"A 'home town treatment' plan not only meets the need which can not be supplied by VA hospitals, but it is treatment supplied to the veterans without separating him from home surroundings. Unless his particular case is one where treatment in a Veterans' Administration hospital is essential the obligation of the government can be met without breaking the contacts of the patient with his family.

"Latitude has been granted to the state association to fit the plan to Ohio needs. The fee schedule is regarded as reasonable. The detail of submitting bills for payment has been reduced to a minimum.

"The Veterans' Administration must still be the one to determine the eligibility of the particular veteran to receive service. Only service-connected cases will rate treatment outside of a VA hospital, except in the case of female patients. Service-connection must depend upon a finding from the facts in each case.

"The association vouches for the plan as being satisfactory to the medical profession. It also assumes some responsibility that the physicians who participate are capable of rendering the kind of service which the Veterans' Administration and the veteran expect. Lists of medical men, who have signified their willingness to participate in the plan, will be submitted to the VA. When a veteran applies to the VA office handling his case and is granted out-patient treatment, he can be given a list of local physicians from which to select a doctor. The doctor may be his family physician. The list will include both general practitioners and specialists.

"Even when no formal adjudication of a case as service-connected has been made, a VA regional manager is empowered to make a tentative determination to secure prompt medical care.

"Paralleling the medical plan, arrangements are being made for local hospital and pharmacy service to the veterans.

"The American Legion is keenly interested in the success of the Ohio plan. Hundreds of doctors in the state have been designated as American Legion Post medical advisers under a plan headed up by Dr. Paul Charlton, Department medical adviser. The medical advisers have agreed to keep the Posts and the Department fully informed as to the way the plan is operating in each locality and to represent the Posts in creating interest and cooperation in the Ohio Plan.

"The success of this plan depends mostly upon the medical profession: How well they cooperate in establishing it, how interested they are in the cases of veterans, how many will join in the plan actively and work with the VA. They will find local American Legion officers everywhere in Ohio ready and willing to help. As the new plan is gotten under way this month, the Department of Ohio wishes it, and all those concerned with it, the greatest success."

V.A. NEWS OF INTEREST

Following are news items of interest regarding the activities of the Veterans Administration:

A new program to insure the early diagnosis and prompt treatment of tuberculosis among hospitalized war veterans is being instituted by the Veterans Administration in Ohio, Michigan, and Kentucky, it was announced at the Columbus Branch Office.

Chest X-rays will be taken of each hospitalized veteran at the time of admission and of each out-patient at the time of scheduled medical examination, regardless of the disability for which the veteran is hospitalized or examined. Periodic surveys of all general and neuropsychiatric patients at the end of each 12 months' hospitalization also have been authorized.

More than 1,000 veterans now are in Veterans Administration hospitals in the three states because of tuberculosis. A tuberculosis hospital is maintained at Outwood, Kentucky, and tuberculosis departments are operated at most of the other hospitals.

CUSHING APPOINTED

Dr. Edward Harvey Cushing, associate clinical professor of medicine at Western Reserve Uni-

versity, Cleveland, has been appointed chief of the division of education in the Veterans Administration Department of Medicine and Surgery.

A veteran of both World Wars, Dr. Cushing will head the training of full-time V.A. hospital employees as well as the residency program with the "Deans Committees". He will work under Dr. Paul B. Magnuson, Acting Assistant Medical Director for Research and Education.

To date, more than half of the 77 Class A medical schools are accepting applications for residencies and approximately 600 physicians already are on duty in V.A. hospitals under the program which started last January. Eventually the number of residents will reach more than 1,000.

Dr. Cushing also will supervise maintenance of training standards and appointment of personnel to key positions at the Army's former Kennedy General Hospital at Memphis, Tennessee, and Winter General Hospital at Topeka, Kansas. Both have been taken over by V.A. and have principal roles in its training activities.

REPORT ON CLAIMS FILED

One out of every three Ohio veterans of World War II has filed a claim with the Veterans Administration for disability pensions, it was announced recently.

Up to June 1, a total of 171,382 claims had been filed, resulting in 79,801 awards. Of the remainder, 83,278 claims were disallowed or had been terminated, and 8,303 were pending adjudication.

In the nation, a total of 3,282,375 claims were filed up to the first of June. Claims approved for compensation or pension totaled 1,516,315 and of the remainder, 1,471,616 claims were disallowed and 294,444 were pending.

More veterans were hospitalized by Veterans Administration during the first nine months of the current fiscal year than during all of the previous fiscal year, Dr. Paul R. Hawley, V.A. chief medical director, has announced.

From July, 1945, through March, 1946, V.A. admitted 250,226 veterans for hospital treatment, compared with 241,013 during the entire 1945 fiscal year. The figure for the nine months of the 1946 fiscal year was an increase of 37.8 per cent over the comparable 1945 period, Dr. Hawley said.

Discharges for the same period numbered 233,982 veterans, compared with 235,022 for the entire 1945 fiscal year.

Dr. Hawley said the number of patients under treatment in V.A. hospitals during the first nine months of the 1946 fiscal year had increased approximately 8,000. He added that the rise to a total of 75,033 had resulted from two main factors:

Number of Physicians Who Have Signed Up To Date To Serve Veterans

FOLLOWING is a tabulation by counties of the number of members of the State Association who have signed up as fee-designated physicians under the Association's veterans medical care plan as of July 23:

Adams	8	Licking	31
Allen	58	Logan	16
Ashland	18	Lorain	69
Ashtabula	27	Lucas	234
Athens	9	Madison	11
Auglaize	12	Mahoning	139
Belmont	25	Marion	23
Brown	3	Medina	15
Butler	57	Meigs	7
Carroll	6	Mercer	6
Champaign	14	Miami	32
Clark	35	Monroe	1
Clermont	10	Montgomery	174
Clinton	12	Morgan	5
Columbiana	34	Morrow	2
Coshocton	10	Muskingum	21
Crawford	19	Noble	3
Cuyahoga	794	Ottawa	11
Darke	17	Paulding	7
Defiance	10	Perry	5
Delaware	9	Pickaway	9
Erie	28	Pike	4
Fairfield	22	Portage	18
Fayette	6	Preble	8
Franklin	307	Putnam	12
Fulton	12	Richland	53
Gallia	6	Ross	18
Geauga	7	Sandusky	19
Greene	17	Scioto	39
Guernsey	14	Seneca	17
Hamilton	479	Shelby	13
Hancock	17	Stark	134
Hardin	12	Summit	177
Harrison	6	Trumbull	49
Henry	5	Tuscarawas	39
Highland	14	Union	10
Hocking	8	Van Wert	13
Holmes	6	Vinton	1
Huron	20	Warren	10
Jackson	3	Washington	19
Jefferson	39	Wayne	27
Knox	14	Williams	8
Lake	24	Wood	20
Lawrence	13	Wyandot	8
TOTAL			3,813

1. A number of Army hospitals have been taken over by V.A. and the Armed services, as well as civilian hospitals, are cooperating more extensively in hospitalizing veterans.

2. The length of time required to treat veterans has been reduced because of improvements in the medical service and the addition of personnel, enabling V.A. to give patients more prompt attention.

The number of veterans under treatment outside of V.A. hospitals had more than doubled under the program to enlist all possible sources of beds for veterans. Dr. Hawley said that more than 10,000 veterans were hospitalized outside of V.A. hospitals on May 30, as contrasted with 4,422 at the end of the fiscal year. These included 1,093 in Federal Security Agency hospitals, 2,156 with the U.S. Army, 3,719 with the U.S. Navy, and 3,415 in civil and state hospitals.

Dr. Hawley said that the number of veterans

with service-connected disabilities under treatment in V.A. hospitals had remained fairly constant during the period. It ran slightly less than one-third of those hospitalized.

Although the number of veterans awaiting hospitalization has risen sharply during the fiscal year, Dr. Hawley pointed out that few of them were service-connected cases and all of these were elective operations of treatment permitting of delay.

In July, 1945, 4,329 veterans were listed as awaiting hospitalization, with 169 having service-connected disabilities. In May, 1946, there were 27,899 awaiting hospital admission, with 270 having service-connected disabilities. Several months ago the number of service-connected cases had neared the 1,000 mark, but this was reduced under the V.A. insistance that veterans with service-connected disabilities be given the highest priority for hospital treatment.

The number of applications for hospitalization have more than doubled during the past 10 months with the figure for May reaching 64,132.

HOSPITAL STAFFS INCREASED

Approximately 1,250 doctors who recently completed their internships under the Army Specialized Training Program and the Navy V-12 Program are reporting to Veterans Administration hospitals.

Under a program worked out jointly by the Army, Navy, and the Veterans Administration, these physicians have been assigned to V.A. hospitals to fulfill their obligations for two years of military duty after completing their internships.

Officials of the Veterans Administration Branch Office at Columbus, serving Ohio, Michigan, and Kentucky, announced that six of the eight V.A. hospitals in the area will benefit in the new program to the extent of 98 additional physicians.

An additional 250 doctors from the Navy's V-12 program are expected to be assigned before September, thus the eventual total will be 1,500 physicians.

While serving their two years the doctors will be on military duty. They have been commissioned either First Lieutenants in the Army or Lieutenants, jg, in the Navy.

A brief indoctrination program is planned so that the physicians may be familiar with Veterans Administration procedures and their responsibilities to veterans.

Special efforts will be made to integrate these young doctors into the professional life of the V.A. hospital with each officer attached to an experienced full-time staff physician who will serve as a preceptor.

NEED PHYSICAL MEDICINE SPECIALISTS

Veterans Administration hospitals in Ohio, Michigan, and Kentucky, covered by Branch Office No. 6, are in need of physicians trained in physical medicine. Annual salaries range from $4,902 to $9,376. Such physicians are in charge of physical therapy, occupational therapy, and correctional physical exercise which will be coordinated with activities for educational retraining, shop retraining, aural rehabilitation, and industrial therapy. Any physician interested should get in touch with Ver Lynn Sprague, executive officer, Medical Rehabilitation, Branch Office No. 6, 52 S. Starling Street, Columbus.

Regional and Sub-Regional Offices Of Veterans Administration

Here are the Veterans Administration offices in Ohio which have authority to authorize home-town physicians to treat veterans with service-connected disabilities and with which physicians should deal on such matters:

Cleveland (Regional)—Cuyahoga Bldg.
Akron (Sub-Regional)—United Building
Canton (Sub-Regional)—Brant Building
Lima (Sub-Regional)—209 N. Main Street
Mansfield (Sub-Regional)—13 Park Avenue, W.
Steubenville (Sub-Regional) — National Exchange Bank Building
Toledo (Sub-Regional)—Huron Building
Youngstown (Sub-Regional)—6 W. Federal Street
Cincinnati (Regional)—230 E. Ninth Street
Dayton (Vet. Adm. Home)—No address required
Columbus (Sub-Regional)—209 S. High Street

NAMED T.B. SPECIALIST

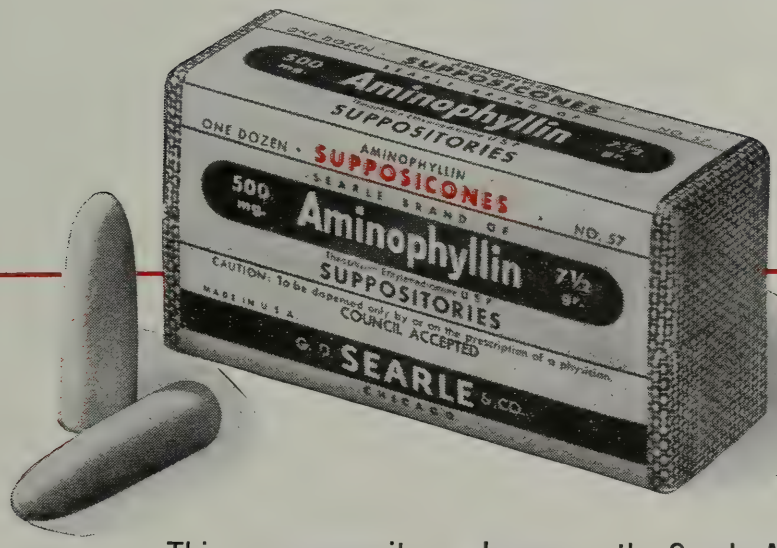
Dr. Meyer Ralph Rosenbloom, Pittsburgh, has been appointed in the Department of Medicine and Surgery of the Veterans Administration. He will assume the duties of senior physician in tuberculosis at the Veterans Administration Hospital, Dayton. Dr. Rosenbloom is a veteran of World War II. He served as Chief of Tuberculosis Section, Brooke General Hospital, Fort Sam Houston, Texas; and earlier had served as a Battalion Medical Officer and as a Battalion Surgeon. Prior to his entrance on active duty with the U.S. Army, Dr. Rosenbloom served as Resident Physician at the National Jewish Hospital, Denver, Colorado, and at the Pennsylvania Tuberculosis Hospital, Cresson, Pa. Dr. Rosenbloom is a member of the American Medical Association.

"HOME-TOWN" PHARMACY PLAN

A program whereby veterans with service-connected disabilities for whom medical care has

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SEARLE RESEARCH IN THE SERVICE OF MEDICINE

been authorized by the Veterans Administration may have prescriptions filled by "home-town" pharmacists and the pharmacist may be paid by the Veterans Administration, has been worked out between the Veterans Administration and the Ohio State Pharmaceutical Association.

Under the agreement which includes only members of the Ohio State Pharmaceutical Association, the veteran may obtain a prescription for drugs and certain medical supplies from the physician who has been authorized to treat him. Regular prescription blanks or special blanks which will be printed by the pharmaceutical association and distributed through its members to physicians may be used.

Here are two important points:

1. Each blank must be dated and the prescription must be filled within 10 days of the date of issuance. Unless the blank is dated and the prescription filled within 10 days, the druggist will not be reimbursed by the Veterans Administration.

2. .Each blank must carry the following wording over the signature of the physician:

"I am authorized to treat and prescribe for the above named Veterans Administration patient." This wording is authority for the pharmacist to fill the prescription and to be compensated by the Veterans Administration.

"MEDICAL REQUISITES"

There are no restrictions upon physicians as to medical agents which may be prescribed but by necessity the term "medical requisite" found in the agreement has been defined as including only the following items:

1. Insulin syringe and two needles.
2. Two hypodermic (insulin type) needles.
3. Atomizer.
4. Nebulizer.
5. Hot water bottle.
6. Fountain syringe.
7. Combination hot water bottle and syringe.
8. Ice bag.
9. Ice cap.
10. Urinal.
11. Bed pan.
12. Enema can.
13. Feeding tube.
14. Ear and ulcer syringe.

The above listed items may be prescribed only in the case of an emergency and each prescription must be limited to a single item.

NO REFILLS ALLOWED

Pharmacists can not be reimbursed for refilling any prescription and for this reason it will be necessary for physicians to write new prescriptions whenever additional drugs are indicated or a new medical requisite is required.

Close cooperation between fee-designated physicians under the Ohio State Medical Association veterans medical care plan and members of the Ohio State Pharmaceutical Association under the pharmacy program will be necessary.

Old Age Pensioners Eligible for Supplemental Relief

Old age pensioners are entitled to supplementary poor relief, e.g., medical care, if in the opinion of the local relief authority the old age assistance award is inadequate to meet the needs of the pensioner, according to Opinion No. 996, rendered by Attorney General Hugh S. Jenkins, June 7.

Syllabus of the opinion follows:

1. A recipient of old age assistance entitled to receive the maximum award payable under the provisions of Section 1359-1, et seq., General Code, is entitled to poor relief if the local relief authority determines that such award is inadequate to meet the needs of such recipient.

2. A recipient of old age assistance is entitled to poor relief, even though not currently receiving the maximum award under provisions of Section 1359-1, et seq., General Code, if the local relief authority determines that by reason of an emergency, or otherwise, such award is inadequate to meet the present needs of such recipient.

3. It is the duty of the local relief authority to furnish poor relief to recipients of old age assistance if such authority determines that the old age assistance award is inadequate to meet the needs of such recipients.

Hoyt Reappointed to Medical Board; Licenses of Several Revoked

Dr. William M. Hoyt, Hillsboro, has been appointed by Governor Lausche to another seven-year term as a member of the Ohio State Medical Board.

Ralph B. Brown, M.D., Columbus, and Roy T. Haskell, M.D., Akron, lost their licenses to practice medicine in Ohio in accordance with action taken by the board at its last meeting, July 2, in Columbus. Both licenses were revoked because of convictions on narcotic violations, according to Dr. H. M. Platter, secretary to the board.

The license of Carl Bratchi, Summit County, a chiropractor, was revoked because of a conviction on a charge of criminal abortion.

The Ohio license of LeRoy Wellstead, M.D., Ottumwa, Iowa, was also revoked. Dr. Wellstead is serving a sentence in Iowa for criminal abortion.

The board will conduct licensing examinations again on December 3, 4, and 5, 1946, Dr. Platter announced.

ANALYSES OF NUTRITIVE VALUES:



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	CHICKEN	LIVER	LAMB	BEEF	VEGETABLE
Solids %	11.8	13.3	13.9	13.7	13.4
Protein %	2.63	3.42	3.09	3.91	1.95
Fat %	1.5	0.9	2.1	0.9	0.5
Carbohydrate % by difference	6.4	7.5	7.2	7.6	9.3
Calories per ounce	14	15	17	15	14
Crude Fibre %	0.15	0.29	0.30	0.22	0.43
Calcium %	0.026	0.013	0.046	0.046	0.024
Phosphorus %	0.042	0.065	0.068	0.068	0.051
Iron Mg. per 100 g.	.22	.72	.35	.40	.73
Copper Mg. per 100 g.	.24	.35	.12	.17	.24
Manganese Mg. per 100 g.	.075	.173	.054	.053	.018
Vitamin A—I. U. Per 100 g.	1766	7000	1130	1693	2550
Thiamine Mg. per 100 g.	.018	.080	.036	.037	.069
Riboflavin Mg. per 100 g.	.040	.62	.068	.072	.064
Ascorbic Acid Mg. per 100 g.	1.1	7.3	2.7	3.9	7.5
Niacin Mg. per 100 g.	.77	1.54	1.22	1.29	1.05

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LOOK FOR THE RED-AND-WHITE LABEL

Ohio Delegates Take Prominent Part in Annual Session of American Medical Association in San Francisco

THE 95th Annual Session of the American Medical Association attracted 7,746 Fellows of the A.M.A. to San Francisco July 1-5, the largest medical assemblage ever held on the Pacific Coast.

The scientific sessions and exhibits were satisfactorily housed in San Francisco's Civic Center, but the unprecedented influx of physicians and their families over-taxed the city's hotel and rooming-house facilities to the extent that private homes and military barracks had to be used to accommodate the visitors.

The scientific sessions were exceptionally well-attended, and the Civic Auditorium, filled to capacity with scientific and technical exhibits, was thronged throughout the week. Features of the Scientific Exhibit included special exhibits by the Army and Navy Medical Departments and special exhibits on Fractures and Physical Medicine. Continuous scientific motion pictures were shown daily in six theaters.

The inconvenience of a street car strike on the eve of the meeting was overshadowed by marvelous weather, excellent local arrangements by the California Medical Association, and the genuine courtesy and hospitality of the people of San Francisco.

OHIO HAD EIGHT DELEGATES

Sessions of the House of Delegates were held at the St. Francis Hotel. The Ohio delegates were: Dr. Barney J. Hein, Toledo; Dr. L. Howard Schriver, Cincinnati; Dr. William M. Skipp, Youngstown; Dr. C. C. Sherburne, Columbus; Dr. Edgar P. McNamee, Cleveland; Dr. D. J. Slosser, Defiance; Dr. George A. Woodhouse, Pleasant Hill; and Dr. Carl A. Lincke, Carrollton. Their reference committee appointments were: Dr. Sherburne, Rules and Order of Business; Dr. Hein, Executive Session; Dr. Skipp, Industrial Health. (Dr. Edward J. McCormick, Toledo, participated in the session as chairman on the Council on Medical Service and Public Relations.)

The Ohio delegation sponsored two resolutions. The first, introduced by Dr. McNamee, on instructions from The Council of the State Association, called on the House of Delegates of the A.M.A. to endorse in principle S. 2143, the Taft-Smith-Ball Bill, introduced in the Senate May 3 by Senator Robert A. Taft, Ohio, for himself, Senator Smith, New Jersey, and Senator Ball, Minnesota, as a counter-proposal for the Wagner-Murray-Dingell Bill. (See July issue, *The Ohio State Medical Journal*, pages 760-761.)

The resolution requested that the Council on Medical Service and Public Relations of the A.M.A. be authorized to confer with the authors of the bill for the purpose of assisting them in drafting proposed amendments which would strengthen and clarify its provisions pertaining to administrative responsibilities and procedures.

CONFAB WITH TAFT VOTED

The Reference Committee on Legislation and Public Relations, to which the resolution was referred, reported to the House of Delegates that it was in accord with the desires of the resolution, but was of the opinion "that the resolution contained considerable controversial matters". The committee recommended: "That the Council on Medical Service and Public Relations of the American Medical Association in conjunction with the Bureau of Legal Medicine and Legislation be authorized to confer with the sponsors of S. 2143 to discuss the features of the bill, and furthermore, that the Council on Medical Service and Public Relations be instructed to report back to the Board of Trustees the results of this conference and be guided by its instruction." The recommendation was adopted by the House of Delegates.

MENTAL HYGIENE RESOLUTION

The second resolution sponsored by the Ohio delegates and presented by Dr. Woodhouse, urged medical support and leadership in state mental hygiene programs. Slightly modified by the Reference Committee on Medical Education, the resolution was adopted by the House of Delegates, as follows:

"WHEREAS, There is need in many of the states for organized and adequately financed programs for the prevention of mental disease, for research activities in the field of mental disease, and for improved institutional care of the mentally ill; and

"WHEREAS, The medical profession should support and give leadership to these activities; therefore be it

"RESOLVED, That the proper agency of the American Medical Association request each state medical society to assume appropriate leadership in the development of adequate mental disease programs within its state and to cooperate with other state and local groups in stimulating public interest and support to assure the proper operation and maintenance of such programs."

PUBLIC RELATIONS ARGUED

A report of the Board of Trustees on a survey of the public relations of the American Medical Association aroused more discussion and comment than any other item considered by the House of Delegates. The survey, conducted by



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a firm of public relations experts during the past six months, was for the purpose of making recommendations for the future conduct of the Association's public relations.

The entire text of the consultant's findings and recommendations was not revealed to the House of Delegates. The report of the Board, presented by Dr. R. L. Sensenich, South Bend, Ind., chairman, stated that "the public relations consultant making the survey came to the conclusion that the fundamental necessity is to separate definitely the functions of scientific interpretations and medical economics and the direction of public relations".

RECOMMENDATIONS ADOPTED

Following a prolonged discussion by the House of Delegates sitting as a Committee of the Whole, the report of the Board of Trustees on the survey of public relations, was apoted unanimously, with the following recommendations:

"1. Stressing the scientific activities of the Association through *The Journal* and through an expanded *Hygeia*, this to be under the supervision of the Editor.

"2. Expansion and revitalization of the Bureau of Medical Economics, with the employment of competent economists.

"3. The constitution of a new Division of Public Relations under the immediate supervision of the General Manager and the general supervision of the Board of Trustees, with an Executive Assistant who is a public relations expert with adequate personnel at its head to coordinate all public relations activities of the Association other than scientific.

"4. With the coordination of all public relations activities in this office, the Council on Medical Service and Public Relations should have its name changed to the Council on Medical Service."

The Council on Medical Service will now concentrate on giving every possible assistance to the development and promotion of prepayment medical care plans through Associated Medical Care Plans, Inc.

MISCELLANEOUS BUSINESS

Other important actions taken by the House of Delegates included:

Adoption of a change in the By-Laws providing for two sessions of the House of Delegates annually, the supplementary session to be held in December.

Instructed the Speaker to appoint a committee to confer with the Board of Trustees on the remainder of the public relations survey for report at the midwinter session of the House of Delegates.

Urged the limitation of the constitution of the Health Organization of the United Nations to problems related only to preventive medicine, standardization of drugs and biologic preparations, and the prevention of dissemination of diseases between nations, and asking that questions related to the nature of medical practice in an individual nation be not considered a function of an international organization.

Established a special committee for the purpose of revising the Constitution and By-Laws of the Association.

Requested the Judicial Council to review, clarify, and recommend to the 1947 session of the House of Delegates such revisions in the Principles of Medical Ethics as may be found necessary and advisable.

Reaffirmed opposition to the Wagner-Murray-Dingell Bill and the Pepper Bill.

Reapportioned the House of Delegates, in accordance with the By-Laws, for 1947, 1948, and 1949, on the basis of one delegate for each 1,000 members or fraction thereof. (The total membership of the House is restricted to 175.) On the reapportionment, California, District of Columbia, North Carolina, and Oregon will each gain one delegate. Ohio, with 6,932 members, Missouri, and Pennsylvania will each lose one.

Referred two resolutions concerning the Medical and Hospital Fund in the National Bituminous Wage Agreement, to the Council on Medical Service with instructions to contact any concerned group for the purpose of protecting the health and welfare of the workers and maintaining proper professional relationship.

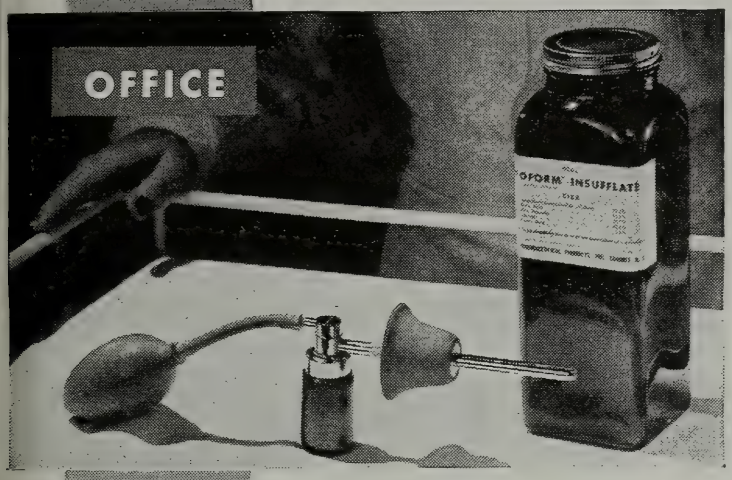
WEST NAMED PRESIDENT-ELECT

The House of Delegates elected the following officers: Dr. Olin West, Chicago, president-elect; Dr. Edward L. Bortz, Philadelphia, vice-president; Dr. George F. Lull, Chicago, secretary; Dr. Josiah J. Moore, Chicago, treasurer; Dr. R. W. Fouts, Omaha, speaker; Dr. F. F. Borzell, Philadelphia, vice-speaker; Dr. Charles W. Roberts, Atlanta, trustee; Dr. Walter F. Donaldson, Pittsburgh, member of the Judicial Council; Dr. Leonard W. Larsen, Bismarck, North Dakota, member of the Council on Scientific Assembly; Dr. Victor Johnson, Chicago, member of the Council on Medical Education and Hospitals; Dr. Edward J. McCormick, Toledo, and Dr. Thomas A. McGoldrick, Brooklyn, members of the Council on Medical Service.

Dr. Roger I. Lee, Boston, retired as President of the Association, and Dr. Harrison H. Shoulders, Nashville, assumed the presidency.

The new President-Elect, Dr. West, was Secretary and General Manager of the Association for 24 years prior to his retirement early in 1946. Born in Gadsden, Ala., in 1874, Dr. West practiced medicine in Nashville, Tenn., and was instructor and later assistant professor at Vanderbilt Medical Department from 1898 to 1910. From 1895 to 1910 he was also Director of the Rockefeller Sanitary Commission and International

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First in the two part treatment is the weekly office procedure. The vaginal vault is washed with tincture of green soap or other agent of choice and dried well. Then VIOFORM INSUFFLATE is employed by means of suitable powder insufflator so as to thoroughly cover the vagina, including the fornices.



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(c) Follow a personal cleanliness routine to eliminate possible reinfection from the rectum.

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Health Board. In 1910, Dr. West became Secretary and Executive Officer of the Tennessee State Board of Health, serving in that capacity until 1918. In the latter year, he went to the Chicago office of the American Medical Association as Field Secretary and was made Secretary in 1922.

CARLSON AWARDED MEDAL

The Distinguished Service Medal for 1946 was awarded by the House of Delegates to Dr. Anton J. Carlson, professor emeritus of physiology at the University of Chicago. Dr. Carlson has contributed many articles on investigations in physiology of the heart and circulation gastric secretions, the nature of hunger and the glands of internal secretion. He has long been a leader in the fight against quackery and in favor of animal experimentation.

The House of Delegates accepted an invitation from New York to meet there in 1949. The 1947 meeting—the one hundredth anniversary of the American Medical Association—will be held in Atlantic City, June 9-13, and the 1948 session will be held in St. Louis, May 10-14.

PARTICIPATE IN PROGRAM

Ohio physicians played a prominent part in planning the scientific sessions and a number participated in the various programs.

Dr. Clyde L. Cummer, Cleveland, a member of the Council on Scientific Assembly, presided at the Tuesday morning general scientific meeting.

Officers of scientific sections included the following Ohioans: Dr. Roy W. Scott, Cleveland, member of the Executive Committee, Section on Internal Medicine; Dr. Cummer, member of the Executive Committee, Section on Dermatology and Syphilology; Dr. Theodore A. Willis, Cleveland, chairman, Section on Orthopedic Surgery; Dr. U. V. Portmann, Cleveland, secretary, Section on Radiology.

Ohio physicians scheduled to take part in scientific sessions as essayists or discussants were: Dr. Chas. A. Doan, Dr. Robert M. Zollinger, Columbus; Dr. Ralph Herz, Dr. C. Lee Graber, Dr. Milton B. Cohen, Dr. John A. Toomey, Dr. A. C. Corcoran, Dr. W. R. Hubler, Dr. E. W. Netherton, Dr. B. B. Sankey, Dr. R. J. Whitacre, Dr. J. K. Potter, Cleveland; Dr. Donald J. Lyle, Dr. Frank H. Mayfield, Dr. Joseph A. Freiberg, Cincinnati.

Scientific exhibits were presented by the following: Dr. A. D. Ruedemann, Cleveland; Dr. K. W. Ascher, Cincinnati; Dr. Lorand V. Johnson, Cleveland; Dr. Milton B. Cohen, Cleveland; Drs. Eugene B. Ferris, George L. Engel, Mrs. George L. Engel, Joseph P. Webb, Charles D. Stevens and M. A. Blankenhorn, Cincinnati; Dr. Benjamin S. Kline, Cleveland; Dr. Samuel Brown, Cincinnati.

Dr. Ruedemann received the Gold Medal in Group I of the Scientific Exhibit for his exhibit on "A Permanent Plastic Eye". Awards are made in this group on the basis of originality and excellence of presentation.

Among the motion pictures shown continuously during the week was one by Dr. Ralph Herz, Cleveland.

Dr. Paul A. Davis, Akron, was the representative to the Scientific Exhibit from the Section on Preventive and Industrial Medicine and Public Health.

Dr. J. R. Tillotson, Lima, was a demonstrator in the special exhibit on Fractures, and Dr. Walter J. Zeiter, Cleveland, assisted in the special exhibit on Physical Medicine.

THOSE WHO REGISTERED

Ohio physicians registered at the San Francisco meeting numbered 200. They were:

Akron—Paul R. Adams, C. R. Andersen, David S. Arbuckle, Paul A. Davis, A. J. Keeley.

Canton—Max E. Baar, A. Alvin Fisher, Ian B. Hamilton, Homer V. Weaver, Pauline Zinninger.

Cincinnati—Charles K. W. Ascher, Samuel Brown, R. J. Buckman, Earl Russell Bush, A. G. Carmel, John T. Crone, Jr., Howard D. Fabing, Eugene B. Ferris, Jr., Douglas Goldman, Ralph Wm. Good, Charles Greenwell, Charles D. Heisel, D. W. Heusinkveld, Benjamin Hoyer, Capt. Albert A. Kunner.

Lt. Joseph A. Lane, Donald J. Lyle, Clarence A. Mills, Dale P. Osborn, Francis M. Oxley, Helena T. Ratterman, C. R. Rittershofer, Daniel C. Rivers, A. Clyde Ross, S. Leon Schiff, L. H. Shriver, T. H. Vinke, Philip Wasserman, Ashton L. Weech, Mendel Zeligs.

Cleveland—George W. Binkley, Louis H. Brooks, Jacob L. Bubis, Arthur C. Corcoran, Wm. F. Creadon, Clyde L. Cummer, John Hart Davis, William E. Dwyer, Harry L. Farmer, Russell L. Haden, Hale De, John E. Hannibal, Ralph Herz, Benjamin S. Kline, Eugene James McCaffrey, Robert H. McDonald, Chas. F. McKhann, E. P. McNamee.

Ursus V. Portmann, James Richard Raines, Donald J. Rehbock, S. L. Robbins, Henry F. Saunders, Ralph A. Scherz, Roy W. Scott, Geo. D. Shaaber, David W. Shallenberger, Taylor Smith, John A. Toomey, John T. Vitkus, Joseph D. Walters, S. F. Weinman, R. J. Whitacre, Theodore A. Willis, Samuel Yamshon, Walter J. Zeiter.

..**Columbus**—R. W. Bonnell, Howard E. Boucher, Richard I. Brashear, Charles A. Doan, J. P. Farson, Walter H. Hamilton, Franklin C. Hugenberger, Robert J. McGuinness, John H. Mitchell, Robin C. Obetz, Paul W. Palmer, Claude S. Perry, C. C. Sherburne, Perry W. Willey, Robert Zollinger.

Dayton—William Abramson, A. T. Bowers, Warren C. Breidenbach, Jr., Albert F. Kuhl, M. V. Lingle, Wm. R. Love, Lt. Douglas W. Lund, Louis E. Ranson, Paul J. Shank.

Toledo—Abel A. Applebaum, A. A. Brindley, Martin W. Diethelm, Fred M. Douglass, E. Benj. Gillette, B. J. Hein, C. E. Hufford, Arthur P. R. James, Luette H. Kuhlman, Edward J. McCormick, Foster Myers, Morris Nelson, C. E.

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Other Cities—Erastus R. Alexander, Rittman; William J. Allison, Springfield; C. T. Atkinson, Middletown; Carle W. Beane, Eaton; Craig Warren Borden, Miamisburg; J. Craig Bowman, Sandusky; C. G. Bozman, Newark; Henry R. Brown, Chillicothe; Guy E. Byers, Salem; C. J. Cassidy, Parma; Eldred L. Clem, Ashland; Lewis Cohen, Bexley; T. H. Copeland, Bedford; Floyd W. Craig, Coshocton; F. R. Crowgey, Salem; E. W. Davis, Alliance; Joseph M. DeNardi, Lorain; W. B. Devine, Zanesville; Robert Murray Dorn, Shaker Heights.

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Paul J. Leahy, Tiffin; Henry W. Lehrer, Sandusky; C. A. Lincke, Carrollton; Layton Harold Martin, Ashland; Esther C. Marting, New Richmond; Lt. Col. Walter H. Matuska, Ottawa; T. G. McCormick, Portsmouth; F. Lambert McGannon, Lakewood; Louis H. Mendelson, Springfield; Gilbert R. Micklethwaite, Portsmouth; M. E. Nichols, Lancaster; George E. Obrist, Portsmouth; Lillian M. Posch, Springfield; William A. Quinn, Portsmouth; V. D. Reichelderfer, Amanda; Edwin A. Riemenschneider, Berea; H. E. Ring, Bellaire; Geo. E. Rockwell, Milford; Geneva L. Shong Rothemund, Yellow Springs.

Gordon E. Savage, Xenia; Warren C. Sawyer, Marion; D. J. Slosser, Defiance; Clifford B. V. Snider, Lancaster; H. L. Sowash, Sandusky; Dan B. Spitler, Hoytville; J. L. Stevens, Mansfield; Maurice E. Stilwell, Massillon; L. D. Stoxier, Stockton; Homer B. Thomas, Gallipolis; J. R. Tillotson, Lima; Lt. T. S. Tonnous, Byesville; J. R. Turner, Springfield; J. L. Webb, Nelsonville; Geo. N. Wenger, Massillon; Theodore H. Will, Minster; G. A. Woodhouse, Pleasant Hill; L. C. Ziegler, Salem.

SPECIAL TRAIN TRIP ENJOYED

The Ohio State Medical Association's special train to San Francisco left Chicago as scheduled on Tuesday noon, June 25, with 130 persons aboard. Following the schedule originally announced, stop-overs for sightseeing were enjoyed at Denver and Salt Lake City, and two and one-half days at Los Angeles.

The return trip, after five days in San Francisco for the A.M.A. meeting, included stop-overs at Portland, Oregon and Vancouver, B. C., followed by three delightful days in the Canadian Rockies at Banff and Lake Louise, returning to Chicago, Friday evening, July 12, after a jaunt of approximately 7,500 miles.

Blessed by magnificent weather, excellent arrangements, generally good accommodations, and an opportunity to view the West in all its scenic grandeur, the "Special Trainers" appeared to enjoy the trip thoroughly.

MEMBERS OF PARTY

Members of the party were: Dr. and Mrs. C. E. Hufford, Toledo; Dr. and Mrs. Fred M. Douglass, Toledo; Dr. and Mrs. J. L. Webb, Nelsonville; Dr. and Mrs. Martin W. Diethelm, Toledo; Dr. and Mrs. George D. Shaaber, Cleveland; Dr. Luette H. Kuhlman and husband, Mr. Jack Devorss, Toledo; Dr. and Mrs. Barney J. Hein and son, Barney, Toledo; Dr. and Mrs. C. J. Cassidy, Cleveland; Dr. and Mrs. Wm. M. Skipp, Youngstown; Dr. and Mrs. E. B. Gillette, Toledo; Dr. and Mrs. H. L. Farmer, Cleveland; Dr. and Mrs. V. A. Killoran and son, Paul, Sandusky.

Dr. and Mrs. Charles H. Halderman, Tipp City; Dr. and Mrs. Earl R. Bush, Cincinnati; Dr. and Mrs. J. L. Bubis, Cleveland; Dr. and Mrs. C. L. Hannum, daughter, Constance, and son, Charles, Plymouth; Dr. and Mrs. R. W. Bonnell, Columbus; Dr. and Mrs. H. E. Boucher, Columbus; Dr. and Mrs. Ralph A. Scherz, Cleveland; Dr. and Mrs. W. B. Devine, Zanesville; Dr. and Mrs. H. B. Thomas, Gallipolis; Dr. and Mrs. Charles T. Atkinson and son, Charles, Middletown.

Dr. and Mrs. F. R. Crowgey, Salem; Dr. and Mrs. L. C. Ziegler, Salem; Dr. and Mrs. A. F. Kuhl and daughter, Pauline, Dayton; Dr. and Mrs. Gilbert Micklethwaite, Portsmouth; Dr. and Mrs. Henry W. Lehrer, Sandusky; Dr. and Mrs. C. E. Price, Toledo; Dr. and Mrs. V. D. Reichelderfer, Amanda; Dr. and Mrs. H. L. Sowash, Sandusky; Dr. and Mrs. C. R. Andersen and daughter, Cynthia, Akron; Dr. and Mrs. Ralph W. Holmes, Chillicothe; Dr. and Mrs. Alan D. Knisely, Lima.

Dr. J. P. Farson, Columbus; Dr. Thomas L. Ramsey, Toledo; Dr. and Mrs. Paul J. Leahy, Tiffin; Dr. and Mrs. William R. Love, Dayton; Dr. and Mrs. Clifford B. Snider, Lancaster; Dr. and Mrs. E. L. Clem, daughters, Vera and Sheila, and son, Eldred, Ashland; Dr. Thomas H. Copeland, Bedford; Dr. and Mrs. D. J. Slosser, Defiance; Dr. William A. Quinn and daughter, Helen, Portsmouth; Dr. and Mrs. M. E. Nichols and daughters, Betty Jeanne and Martha, Lancaster; Dr. and Mrs. J. R. Tillotson and daughter, Catherine, Lima.

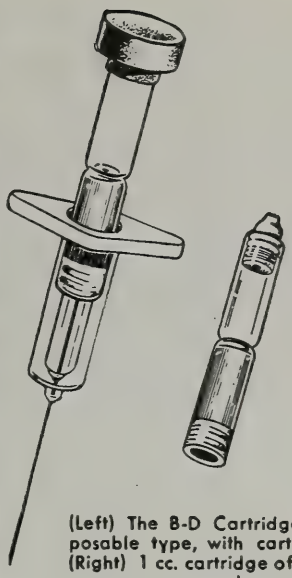
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Dr. L. Howard Schriver, Cincinnati, and Dr. E. R. Alexander, Rittman, joined the Special Train Party at San Francisco for the return trip.

Dr. Charles Ascher, Cincinnati, read a paper on "Further Observations on Aqueous Veins" at the Annual Meeting of the American Association for Research in Ophthalmology, held in San Francisco on July 2.

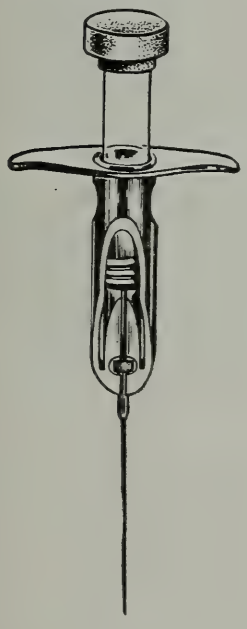
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Compulsory Sickness Insurance Measures Appear to Be "Dead Ducks" in Present Session of the Congress

"DIED in Committee", appeared to be the fate of the Wagner-Murray Dingell Bill, S. 1606, and the Pepper Bill, S. 1318, as this issue of *The Journal* went to press and the 79th Session of the Congress neared its close.

Hearings on the W-M-D bill, which began on April 2, were concluded on July 11 with no action by the Senate Committee on Education and Labor except to order the 2,500-page testimony printed.

Reports from Washington indicate that the advocates of compulsory health insurance are already preparing a revised version of S. 1606 for presentation to the 80th Congress which will convene in January, 1947.

LAST-MINUTE SPASM

Proponents of the Pepper Bill, to extend the Emergency Maternity and Infant Care program for the wives and children of enlisted men to all women and children regardless of economic status, made a last-minute attempt to gain the Committee's approval.

During a brief hearing, testimony favorable to S. 1318 was presented by Miss Katherine Lenroot, chief, and Dr. Martha Eliot, associate chief of the U.S. Children's Bureau, and representatives of the National Congress of Parents and Teachers, Association for Childhood Education, Congress of American Women, and the National Society for Crippled Children and Adults.

Appearing in opposition were: Dr. Joseph Howard, Hartford, representing the American Medical Association; Dr. Joseph Wall, Washington, representative of the A.M.A., and the American Academy of Pediatrics; and Dr. C. W. Camalier in behalf of the American Dental Association.

An executive session to further consider the Pepper Bill was called for July 15, a procedure which was protested by the Ohio State Medical Association and other medical groups. The committee took no action on the bill, but voted to instruct Senators Taft and Pepper to draft a resolution proposing to increase the present regular appropriations for Maternal and Child Welfare under Title V of the Social Security Act.

LARGER GRANTS SOUGHT

On July 15, Senators Taft and Pepper introduced SJR 177, to provide for increased grants to the states for crippled children, maternal and child health, and child welfare, without extending the functions or activities of the U.S. Children's Bureau. The resolution was referred to the Senate Committee on Finance. The proposed increases are:

$5,000,000 to $15,000,000 for the promotion of health of mothers and children; $3,870,000 to $10,000,000 for the care of crippled children; $1,510,000 to $5,000,000 for child welfare services; $1,500,000 for administrative purposes.

Health Commissioners Conference Is Scheduled for Sept. 5-6

The twenty-seventh annual conference of the Ohio Health Commissioners will be held in Columbus September 5 and 6 at the Deshler-Wallick Hotel.

The final program has not yet been prepared, but tentative arrangements provide for the following:

A discussion of "The Purpose and Activities of the National Sanitation Foundation", by Mr. Walter F. Snyder of the Foundation at the University of Michigan; "Shock Therapy in the Management of the Mentally Ill", Dr. Frank Tallman, Commissioner, Division of Mental Diseases, State Department of Public Welfare.

"The Value of Vital Statistics to the Health Department and Staff Members", Mr. A. J. Barowski of the Toledo Department of Health; "Histoplasmosis", Dr. Charles Doan, Dean of the College of Medicine, Ohio State University.

"Local Health Organization and Services", Dr. Haven Emerson of Columbia University. A question and answer period with a participating panel of the staff of the State Department of Health will follow the speakers.

Dr. E. P. McNamee, president of the Ohio State Medical Association, has accepted an invitation to speak at a dinner meeting, September 5.

Dr. Fordyce Retires

Dr. O. O. Fordyce retired July 2 after 27 years as superintendent of the Toledo State Hospital. He was succeeded by Dr. Joseph E. Duty, his assistant since 1938. Dr. Fordyce became a staff member of the state hospital in Athens in 1906 and was named superintendent three years later. In 1919 he became superintendent of the Toledo institution. Dr. Fordyce estimates that approximately 65 per cent of his patients have been sent home as recovered or in comfortable mental health. Dr. Duty is 33 years of age and a native of East Liverpool.

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Federal Security Agency Reorganized; Important Changes Affecting Health and Welfare Setup Enumerated

PRESIDENT Truman's Reorganization Plan No. 2, revamping the setup of the Federal Security Agency, was approved by the U.S. Senate on July 15 and became effective July 16.

In addition to abolishing the three-member Social Security Board and providing for the coordination of grant-in-aid programs, the reorganization plan transfers the functions of the Employees Compensation Commission, the Children's Bureau (with the exception of its child labor functions which remain with the Department of Labor), and the Division of Vital Statistics to the Federal Security Agency.

Under authority granted to him under the plan, Federal Security Administrator Watson B. Miller has made major changes in the agency organization as follows:

The agency will be reconstituted under four main operating branches and six staff offices. The four branches are:

Social Security Administration: This will take over the old-age and survivors insurance, employment security, and public assistance programs formerly administered in the agency by the Social Security Board which was abolished by the reorganization plan, together with activities of the Children's Bureau, except its child labor functions. Arthur J. Altmeyer, who served as chairman of the Social Security Board, has been appointed Commissioner for Social Security to head this new unit. Miss Katherine Lenroot, chief of the Children's Bureau, will continue in that post.

Education: This unit will consist of the existing Office of Education and will be headed by John W. Studebaker, incumbent Commissioner of Education.

Public Health: Consisting of the United States Public Health Service, this unit also will administer Freedman's and St. Elizabeth's Hospitals and will take over the functions of the Division of Vital Statistics, transferred from the Department of Commerce. Dr. Thomas Parran will continue as Surgeon General of the Public Health Service and Halbert Dunn will remain as head of the Vital Statistics Division.

Office of Special Services: This new department will include the newly-created Bureau of Employees Compensation and the Employees Compensation Appeals Board, which succeeded the U. S. Employees Compensation Commission; the Food and Drug Administration; and the Offices of Vocational Rehabilitation, War Property Distribution, and Community War Services. Mrs. Jewell W. Swofford, former chairman of the U. S. Employees Compensation Commission, will direct this office.

In addition to these four operating branches, existing staff offices have been augmented by two new offices, namely:

Office of Federal-State Relations which will be responsible to the Administrator for study and recommendations with respect to coordination of grant-in-aid administration, establishing of uniform standards and procedures, etc. George E. Bigge, member of the former Social Security Board, will head this office.

Office of Inter-Agency and International Relations, headed by Mrs. Ellen S. Woodward, member of the former Social Security Board, which will be responsible to the administrator for formulating, establishing, and coordinating the agency's relationship with other Federal agencies, international agencies, and organized groups in the fields of health, education, welfare, and social security.

COMING MEETINGS

Ohio State Medical Association, Cleveland, May 6-8, 1947.

American Medical Association, Atlantic City, June 9-13, 1947.

American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Hot Springs, Va., Sept. 5-7.

American College of Surgeons, Cleveland, Dec. 16-20.

American Congress of Physical Medicine, New York City, Sept. 4-7.

American Dietetic Association, Cincinnati, Oct. 14-18.

American Public Health Association, Cleveland, Nov. 12-14.

American Roentgen Ray Society, Cincinnati, Sept. 17-20.

Interstate Postgraduate Medical Association, Cleveland, Oct. 15-18.

Mississippi Valley Medical Society, Sept. 25-27, St. Louis.

National Society for the Prevention of Blindness, New York, Nov. 25-27.

The Veterans Administration had 3,651 full-time physicians on its staff as of June 21, an increase of almost 50 per cent in the past six months. Its personnel now includes 612 dentists and 7,985 nurses.

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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

ASK YOUR CONGRESSMAN TO SEND YOU REPORTS ON HEARINGS

We suggest that physicians ask their respective Congressmen to send them copies of the hearings conducted on the Wagner-Murray-Dingell Bill, S. 1606, and the Pepper Bill, S. 1318. By doing so they will be letting members of Congress know that they are interested in and following proposed medical and health legislation. It is a good way to maintain a relationship with members of Congress.

The volumes will contain the arguments pro and con on these measures, much of which will be useful to physicians who are called upon to discuss these questions in public or among their acquaintances. It's always well to know the views and arguments of your opponents in a debate. Don't think the proponents of these bills are going to overlook the opportunity to study what was said in testimony by representatives of the medical profession.

Let's keep posted on all angles of this battle which is just beginning to get to the warm stage.

CHILD HEALTH STUDY MERITS SUPPORT OF ALL DOCTORS

In about another month, all Ohio physicians will receive literature and blanks from the Ohio Study of Child Health Services asking them to file certain statistical information.

It is hoped that each Ohio doctor will cooperate 100 per cent on this matter and submit promptly the data requested.

The survey is being made by the Ohio pediatricians as a part of a nation-wide study conducted by the American Academy of Pediatrics. The project has the official approval of The Council of the Ohio State Medical Association.

The purpose of the study is to obtain reliable information regarding existing medical and health facilities and services available to children. In this way, authentic data can be obtained, which will be of great value in determining the need, if any, of new or extended programs in the field of child health. Also, the study will provide data which may be helpful in answering the demands of those who are backing elaborate programs such as the Pepper plan for a national, socialized child health program.

In the past the medical profession has viewed with skepticism the so-called factual data which have been collected and publicized by certain organizations and agencies interested in extension of government medical and health services, and rightly so.

Here, however, is a sincere effort by a group within the medical profession to obtain certain facts and to make recommendations based on sound statistics and observations. For that reason alone, the Ohio study deserves the enthusiastic support of the medical profession collectively and individually. This is the correct way to find out the real needs in this field so a constructive program can be formulated in Ohio—one based on actual needs, not on phoney data.

LETTERS FROM TWO OHIO MEMBERS OF CONGRESS

When a legislator frankly tells a constituent just how he feels about a piece of pending legislation, it's news. Too many of our legislative representatives used "canned" replies, which are, to say the least, not very reassuring, even on occasions when their minds are made up as to how they intend to vote. To expect a change in this technique probably would be expecting too much, but we can hope.

In contrast to the above custom are two letters received recently at the Columbus office of the State Association in reply to communications from the Association regarding certain measures before the Congress. We are publishing excerpts from them because they typify the kind of letters a constituent likes to get, regardless of which side he may be on.

Writes U. S. Senator James W. Huffman of Ohio:

"I am very glad to have your letter and enclosures of July 15 concerning S. 1318. The Wagner-Murray-Dingell Bill (S. 1606) will not be voted on at this session. I doubt very much if the Pepper Child Health Bill will either. It is not my purpose to be a party to the socialization of the practice of medicine. I am quite sure you know that without my telling you."

Veteran Congressman Thomas A. Jenkins of the 10th Ohio District penned this interesting letter:

"I have your letter and I have read the resolutions which you adopted and have also read your health program. (Note: "A Health Program for Ohio.")

"I agree with you in both instances. Now that we are again in peace times I think we can do away with that Emergency Maternal Program which was largely a war time program.

"I want to congratulate your great profession on its forward looking health program for the State of Ohio. Your action in this respect proves that the medical profession has at heart a very laudable interest in public health. I have often said that the doctors do more for nothing than any other profession. We lawyers are often criticized for our professional activities, but to the credit of our profession I can remember that we, too, have also always been in the front line



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in all fights for liberty and freedom and for the best interests of the people generally. I can remember when the Workmen's Compensation Law was being considered in Ohio its main proponents were lawyers."

Other Congressmen please note:

This publication welcomes the opportunity to publish letters and comments from and by them, providing they are of news value.

"MEDICAL POLITICIANS"? MORE OF THEM NEEDED

Elsewhere in this issue of *The Journal* appears a story on the recent San Francisco session of the American Medical Association, including a resumé of the actions of the House of Delegates.

Because of space limitations, (yes, there is still a paper shortage) the article is necessarily brief—but physicians who are interested—and every member of the A.M.A. should be—may read the complete proceedings of the House of Delegates session in the July 13 and 20 issues of *The Journal of the A.M.A.* The report of the Board of Trustees on the public relations survey is particularly interesting.

A perusal of these proceedings could be likened to taking the pulse of a patient—not a sick one—but one that needs a periodic health examination. Read the proceedings, doctor, and make your own diagnosis! The prognosis is hopeful, in our opinion.

And while we're at it, we'd like to get in a plug for the members of the Ohio delegation. Conscientious in their attendance at all sessions of the House of Delegates and those of reference committees, they had little or no opportunity to attend the scientific meetings.

Medical politicians? If there was a misnomer, it's that one. What the profession needs is more members willing to sacrifice their time and money in behalf of organized medicine, taking on the jobs that have to be done in the county, state, and national medical societies. Anyone so inclined does run the risk of being labeled a "medical politician" by those who shun the thankless tasks, but there is a lot of personal satisfaction in the knowledge that he has done his share in the battle to strengthen medical organization and preserve the private practice of medicine.

Proctologists Organize Society

A group of Cincinnati proctologists recently organized the Cincinnati Proctologic Society at the Hotel Gibson in that city. Founders include: Dr. F. M. Oxley, Dr. Charles E. Howard, Dr. C. R. Deeds, Dr. Gerson Carmel, Dr. A. Clyde Ross, Dr. John T. Crone, and Dr. Stewart R. Jones. Dr. Carmel was elected president; Dr. Crone, vice-president; and Dr. Jones, secretary-treasurer.

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● A Doctor's life isn't his own to live as he chooses. There are interrupted holidays and vacations and nights of broken sleep. Emergencies require his presence for long, exacting hours . . . with somewhere a pause and perhaps the pleasure of a cigarette. Then back to his job of serving the lives of others.



According to a recent independent nationwide survey:

More Doctors Smoke Camels

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Names of 63 Additional Ohio Physicians Added to List of Medical Officers Separated from Services

FOLLOWING are the names of additional Ohio physicians who have been released from military service or have started terminal leave, according to information received by *The Journal*. The rank shown is based on latest data on file with the State Association and, of course, may not be up to date in all instances.

Name	City	Rank
Ackerman, Garrett B.	Columbus	Capt., A.U.S.
Andrews, Stanley B.	Toledo	Capt., A.U.S.
Asbury, Charles W. (formerly of Hamilton)	Slab Fork, W. Va.	1st Lt., A.U.S.
Barker, Myron J.	Lima	Capt., A.U.S.
Becker, Dwight L.	Leipsic	Capt., A.U.S.
Binzer, Isadore	Toledo	1st Lt., A.U.S.
Blazewicz, S. J. (formerly of Columbus)	Pomeroy	Capt., A.U.S.
Butcher, Wendell A.	East Cleveland	Comdr., U.S.N.R.
Canowitz, Aaron S.	Columbus	Capt., A.U.S.
Chrispin, John W., Jr. (formerly of Dayton)	Montpelier, Ind.	1st Lt., A.U.S.
Coombs, Frederick S.	Youngstown	Lt. Col., A.U.S.
Diamond, Adrian	Cincinnati	Lt. Comdr., U.S.N.R.
Docter, Luebert (formerly of Genoa)	Cleveland	Capt., A.U.S.
Eddy, Ford E.	Marietta	Lt., U.S.N.R.
Egolf, Charles F.	Cincinnati	Capt., A.U.S.
Fralick, Charles E. (formerly of Columbus)	Cleveland	Lt., U.S.N.R.
Friedman, Edward	Cincinnati	Comdr., U.S.N.R.
Fry, Francis O.	Cleveland	Lt. Comdr., U.S.N.R.
Goodman, Julien M.	Cleveland	Major, A.U.S.
Grimm, Paul E.	Worthington	Lt. (jg), U.S.N.R.
Harnick, Manning G. (formerly of Middleport)	Perham, Minnesota	Capt., A.U.S.
Hibbs, Ralph E.	Cleveland	Major, A.U.S.
Hawley, Chapin	Cincinnati	Capt., A.U.S.
Herrick, Richard B.	Cleveland	Capt., A.U.S.
Kiess, John S.	Bucyrus	Capt., A.U.S.
King, James D. (formerly of Columbus)	Dayton	Capt., A.U.S.
Main, Robert E. (formerly of Cincinnati)	Athens	Lt. (jg), U.S.N.R.
Mallett, Dean W.	Springfield	Capt., A.U.S.
Marshall, Robert L. (formerly of Columbus)	Painesville	Capt., A.U.S.
May, James R.	Cleveland	Lt. Col., A.U.S.
McGuire, Charles W.	Elyria	Capt., A.U.S.
Miller, Rollis R.	Youngstown	Major, A.U.S.
Niple, Richard A.	St. Clairsville	Capt., A.U.S.
Norcross, Nathan C. (formerly of Toledo)	Oakland, California	Comdr., U.S.N.R.
Nozik, Benjamin	Cleveland	Capt., A.U.S.
Oakes, Milton C.	Mansfield	Lt. Col., A.U.S.
Ochs, Carl J.	Cincinnati	Major, A.U.S.
Oxley, Charles M.	Cincinnati	Capt., A.U.S.
Pagano, James J.	Canton	Capt., A.U.S.
Parker, George J. (formerly of Columbus)	St. Louis, Missouri	Capt., A.U.S.
Pelton, Bernard L. (formerly of Toledo)	Long Beach, Calif.	Lt. Col., A.U.S.
Phillips, C. A.	Toledo	Capt., A.U.S.
Reading, Robert A.	Cleveland	Comdr., U.S.N.R.
Ruch, Ralph O. (formerly of Lima)	Omaha, Nebraska	Surg., U.S.P.H.S.
Rust, Cecil F.	Dayton	Asst. Surg., U.S.P.H.S.
Schauer, Joseph R.	Dayton	Major, A.U.S.
Schnitker, Maurice	Toledo	Lt. Col., A.U.S.
Schock, H. Charles	Cleveland	Major, A.U.S.
Slavin, Francis J. (formerly of Cincinnati)	Roanoke, Virginia	Lt. (jg), U.S.N.R.
Smith, Howard W.	Ashland	1st Lt., A.U.S.
Snyder, Robert D.	Dayton	Lt. Col., A.U.S.
Sprague, Edward A.	Athens	Lt. (jg), U.S.N.R.
Starbuck, Ralph J.	Salem	Major, A.U.S.
Steele, Wendell M.	Newark	Lt. Col., A.U.S.
Stewart, James V.	Massillon	Capt., A.U.S.
Stiles, Henry T.	Mansfield	Major, A.U.S.
Turner, Oscar A.	Youngstown	Lt. Col., A.U.S.
Voegele, Albert H. (formerly of Mansfield)	Boston, Massachusetts	Capt., A.U.S.
Wallace, Richard H.	Columbus	Major, A.U.S.
Widrich, Jack	Cadiz	Capt., A.U.S.
Wilkins, John M.	Marysville	Capt., A.U.S.
Woodworth, Philip J.	Athens	1st Lt., A.U.S.
Yingling, Walter E.	Lima	Major, A.U.S.

Military News Notes

Dr. Claude S. Perry, Columbus, now acting chairman of the Department of Ophthalmology, Ohio State University College of Medicine, has been awarded the Bronze Star Medal for meritorious service while in Belgium as chief of EENT of the 76th General Hospital. Lt. Col. Perry was in the service for nearly five years.

* * *

The Legion of Merit has been awarded to Dr. Spencer Braden, Cleveland, in recognition of his outstanding service during World War II. Lt. Col. Braden was chief of neurosurgery at Nichols General Hospital, Louisville, Ky.

* * *

Dr. Joseph M. Hayman, Jr., professor of clinical medicine and therapeutics, and Dr. Claude S. Beck, professor of neurosurgery at Western Reserve University School of Medicine, have been named consultants to the Secretary of War. They are among 74 physicians and surgeons appointed by the Surgeon General to "evaluate, promote, and improve, wherever possible, the quality of medical care given American soldiers". Both attained the rank of colonel in the recent war.

* * *

For "distinguishing himself by valor and splendid spirit of self sacrifice", Dr. Kenneth F. Lowry, Troy, has been honored with the Italian Military Valor Cross by the Italian Government. Lt. Col. Lowry participated in the Italian Campaign as chief of the 2nd Auxiliary Surgical Unit.

* * *

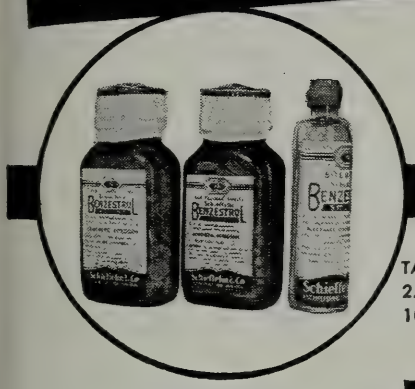
Col. Arthur H. King, Alliance, has been awarded the Bronze Star Medal for meritorious service in connection with military operations from Nov. 12, 1942, to Nov. 22, 1943, when he was Surgeon of the New Caledonia and Espiritu Santo Service Command.

* * *

The Army Commendation Ribbon and a Certificate for Meritorious Service have been presented to Maj. Lawrence C. Goldberg, Cincinnati, now on terminal leave. Dr. Goldberg was chief of a neurosyphilis and skin center at Oliver General Hospital, Augusta, Ga.

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VETERANS' INQUIRY DEPARTMENT

Ohio Openings and Locations Sought by Returning Medical Officers; Opportunities Available Listed

THE purpose of this department is to provide space without cost to Ohio veteran physicians for the publication of inquiries they may wish to make concerning an assistantship or residency, a partnership or space in an office, locations and purchase of a practice, purchase of equipment, etc.

The new feature also offers an opportunity for physicians who desire to dispose of their practice or institutions and agencies needing staff physicians to publicize this information for the benefit of service men.

The feature will appear monthly as long as there seems to be a need for it. The regulations governing it are: (1) The veteran submitting the inquiry must be an Ohio physician, i.e., one who was in practice in Ohio when he entered the service or was a native of Ohio but still in training when he entered in the service. (2) Inquiries should not exceed 35 words. (3) Copy must be submitted by the 20th day of the month preceding date of publication. (4) Unless otherwise specified, each inquiry will be carried in two consecutive issues of *The Journal* but no oftener. (5) *The Journal* reserves the right to reject or edit copy submitted; also, to eliminate the new department when and if conditions warrant. (6) Inquiries should be accompanied by full name, forwarding address and identifying data.

OPPORTUNITIES SOUGHT

LOCUM TENENS DESIRED: Wanted for three months beginning September 15 by Navy medical officer who will begin residency January 1. Graduate of Harvard Medical School in 1944; aged 26; internship Lakeside Hospital, Cleveland. V.I.D. No. 22.

SEEKS INDUSTRIAL ARRANGEMENT: Veteran with extensive industrial background seeks association with individual or group in this type of practice. Willing to invest. Cleveland area preferred but others also considered. V. I. D. No. 23, care of Ohio State Medical Journal.

ASSISTANTSHIP WANTED: Assistantship to general practitioner or radiologist sought by naval officer to be discharged September 1. Age 28. Ohio license. Graduate of Cincinnati University College of Medicine. Rotating internship. Two and one-half years part-time civilian and two years Navy roentgenology. V.I.D. No. 24.

ASSISTANTSHIP WANTED: Navy veteran desires assistantship with busy general practitioner or obstetrician. Graduate of University of Louisville School of Medicine, 1944; rotating internship. Aged 24; single. V.I.D. No. 25.

ASSOCIATION DESIRED: Veteran desires position with small medical group or assistantship with pediatrician or general practitioner in town over 20,000. Ultimate desire is to specialize in pediatrics. V.I.D. No. 26.

ASSISTANTSHIP WANTED: Surgeon, aged 32, Army experience and eligible to American Board of Surgery, available in Fall of 1946, desires assistantship to older surgeon, group practice, association with internist, etc. Experience in general surgery, neurosurgery, orthopedic surgery; Ohio license. V.I.D. No. 27.

OPPORTUNITIES OFFERED

OPENING FOR ANESTHETIST: Diplomate of Board of Anesthesiology or fellow of American Society of Anesthesiology wanted as an associate or to practice independently as a full-time anesthetist. Write Fred W. Brosius, M.D., Middletown, Ohio.

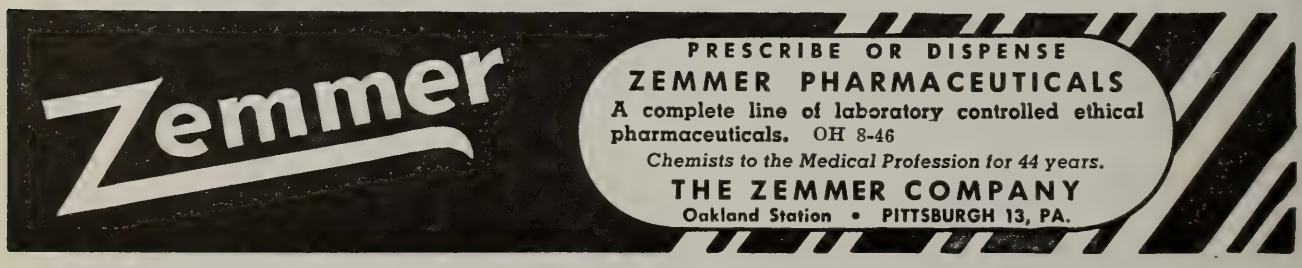
PRACTICE AVAILABLE: General practice in DeGraff available. No property to sell. Forced to retire because of health. Good field for lively young physician. Write O. W. Loffer, M.D., DeGraff.

LOCUM TENENS WANTED: Need physician to take over practice for three to six months due to illness. Single veteran preferred. Home available. Possible opportunity to buy practice later. G.A.S., care of Ohio State Medical Journal.

INTERNS AND HOUSEMEN NEEDED: Good Samaritan Hospital, Dayton, has openings for six interns. Internships approved by American Medical Association. Weekly seminars offered by members of various specialty boards. Also vacancies for four returning veterans as housemen; also entitled to seminars. Stipends for interns $50.00 with full maintenance; stipends for housemen, $150.00 with full maintenance. Contact Intern Committee of hospital.

OPENING FOR GENERAL PRACTICE: Opening in Toledo for young man interested in general practice (surgically inclined) to reopen a former well-established practice. Office completely furnished. Reason: Limiting practice to internal medicine. Excellent location for future group practice. D.O.M., care of Ohio State Medical Journal.

PRIVATE INDUSTRIAL PRACTICE: Good opportunity for young physician who wishes to engage in private industrial practice in industrial center. Physician now handling work changing locations. If interested, write T.H.L. care of Ohio State Medical Journal.



CLINIC STAFF OPENING: Opening for young man interested in general practice on staff of group clinic. Compensation first few months on salary basis; thereafter on percentage basis. All equipment furnished by clinic. L.A.C. care of Ohio State Medical Journal.

PART-TIME INDUSTRIAL PRACTICE: Good opening for physician interested in part-time industrial practice, physical examinations, and emergencies. Columbus industrial firm. Write C.W.C., care of the Ohio State Medical Journal.

INDUSTRIAL COMMISSION: Openings available in Medical Section, Ohio Industrial Commission. Consult Dr. Robert André, chief supervisor, Medical Section, State Office Bldg., Columbus.

STATE HOSPITAL STAFF OPENINGS: Staff physicians for various institutions serving the mentally ill, mentally defective and epileptic needed. Physicians who have had some psychiatric training or experience preferred but can offer positions to doctors who may be interested in becoming acquainted with the specialty. Two positions of special importance now open are: Superintendency, Youngstown Receiving Hospital (especially attractive for young physician with residency in psychiatry) and Clinical Directorship, Gallipolis State Institute (fine opportunity for man who has had neuropsychiatric training to become acquainted with those neurological conditions that cause epilepsy in addition to a chance to be a specialist in the field of true epilepsy). Consult Dr. Frank F. Tallman, Ohio Commissioner of Mental Hygiene, State Departments Building, Columbus 15.

PUBLIC HEALTH OFFICERS NEEDED: Several counties in Ohio in need of full-time health commissioners. Those with training and experience, or interested in public health work, may obtain complete details from Dr. Roger Heering, Ohio Director of Health, State Departments Building, Columbus 15.

PRACTICE FOR SALE: Active practice in a community of 3,000, North Central Ohio. Large amount of industrial work in addition to regular practice. Equipment includes new X-ray, diathermy, modern furniture, drugs and supplies. No real estate for sale. Moderate rent. Estimated price $7,500, cash or terms. Will introduce for a short time. Write R.J.S., care of Ohio State Medical Journal.

TUBERCULOSIS HOSPITAL OPENING: Resident physician needed in this institution doing intensive collapse therapy, including surgery. Good opening for man who desires to enter this field of medicine. District Tuberculosis Hospital, Lima; H. H. Brueckner, M.D., superintendent.

VETERANS ADMINISTRATION: Openings for physicians as members of rating boards for either full time or part time duty. Basic salary $4300.00 per annum, with additional compensation for overtime. Contact nearest V.A. office for particulars.

PRACTICE AVAILABLE: General practice at Friendship, Scioto County; seven miles from Portsmouth, which has two hospitals; population of area about 8,000; centralized elementary school; within six miles of High School; two Protestant churches; combined residence and office, with four-acre plot, available for sale or rent; no other physician in community. G.F.J., care of Ohio State Medical Journal.

FULL-TIME RESIDENT PHYSICIAN NEEDED: At Homeplace, Perry County, Kentucky, operated by E. O. Robinson Mountain Fund as educational center for mountain people. Graduate nurse; clinic building being planned; affiliation with medical center in Cincinnati for consultation and specialized services; salary $5,000 per year, with home and transportation furnished. Write Dr. Howard P. Fischbach, 1122 Carew Tower, Cincinnati 2, Ohio.

PRACTICE AND HOME FOR SALE: Active practice established 10 years in town of 2000 with local post office serving 8000. Brick and stone home with modern interior. Has suite of rooms for office. All modern office equipment with stock of drugs and X-ray, diathermy, ultraviolet. Seeing more than 20 patients per day. Physician urgently needed. Forced by service-connected disability to retire from general practice. All is offered to a veteran for price of real estate alone. Liberal terms; can pay for all in three years from earnings. M. R. Wedemeyer, M.D., Oak Hill, Ohio.

Still active in the practice of medicine despite his 92 years, Dr. Edwin W. Mitchell, Cincinnati, attended Commencement at Ohio Wesleyan University, Delaware, in June. He was the only member present of the Class of '76, holding its 70th reunion.

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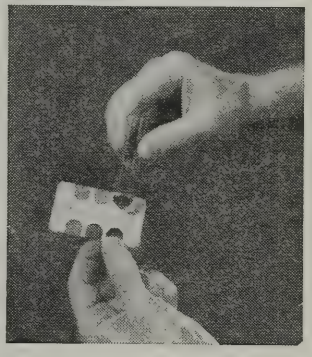
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In Memoriam

Merle Jay Brickman, M.D., Cleveland; Western Reserve University School of Medicine, 1911; aged 63; died June 26; member of the Ohio State Medical Association and the American Medical Association. A native of McComb, Ohio, Dr. Brickman had practiced medicine in Cleveland for 35 years. From 1927 to 1940 he taught anatomy at the Western Reserve University School of Dentistry. He was a Mason and a charter member of the Acacia Country Club. Surviving are his widow, his mother, a brother, and four sisters.

William Francis Brokaw, M.D., Cleveland; University of Wooster Medical Department, Cleveland, 1890; aged 85; died June 17; former member of the Ohio State Medical Association and the American Medical Association. Dr. Brokaw had retired from active practice in September, 1945. He was a charter member of the Cleveland Medical Library and was one of the 13 physicians who founded the Cleveland Academy of Medicine, of which he was the first secretary. His widow survives.

Ray Brown, M.D., Columbus; Ohio State University College of Medicine, 1930; aged 51; died July 11; member of the Ohio State Medical Association and Fellow of the American Medical Association. Dr. Brown had practiced in Columbus since 1930 and was a member of the United Presbyterian Church and the Masonic order. He was a veteran of World War I and a Selective Service examiner during World War II. His widow and a son survive.

Jerome Hartman, M.D., Dayton; Jefferson Medical College of Philadelphia, 1923; aged 48; died June 29; member of the Ohio State Medical Association and Fellow of the American Medical Association; certified by the National Board of Medical Examiners in 1927; certified by the American Board of Orthopaedic Surgery; member of the American Academy of Orthopedic Surgeons. Dr. Hartman was chief of the orthopaedic staff at Miami Valley Hospital for two years and served as a commander in the Navy Medical Corps in World War II. He had practiced in Dayton for 22 years. Surviving are his widow, two brothers, and two sisters.

George Ambrose Henry, M.D., Tuscarawas; Ohio Medical University, Columbus, 1897; aged 78; died July 2; member of the Ohio State Medical Association and the American Medical Association. Dr. Henry had been a practicing physician for more than 50 years, having opened his first office in Adams Mills. He was a native of Zanesville. Surviving are his widow, two daughters, a brother, and a sister.

Walter Scott Holley, M.D., Toledo; Eclectic Medical College, Cincinnati, 1920; aged 53; died

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BLOOD CHEMISTRY — X - RAY DIAGNOSIS
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June 25; member of the Ohio State Medical Association and the American Medical Association. Dr. Holley had practiced in Toledo for 27 years and was City Health Commissioner in 1932 and 1933. He was a member of the Masonic Lodge and the Presbyterian Church. Surviving are his widow, a daughter, his mother, and two brothers.

Frank O. Hunt, M.D., Adamsville; Northwestern Ohio Medical College, Toledo, 1891; aged 77; died June 9. Dr. Hunt maintained an office in Adamsville for the past 27 years and in Zanesville for the past 15 years. He was a member of the Catholic Church. Surviving are his widow, five sons, and a daughter.

James Joseph Jennie, M.D., Cincinnati; Miami Medical College, Cincinnati, 1907; aged 62; died July 4; member of the Ohio State Medical Association and the American Medical Association. Dr. Jennie was on the staffs of Deaconess, General and Children's Hospitals. During World War I he served as a captain in the U.S. Army Medical Corps. He is survived by his widow, a son, a daughter, and two brothers.

Lewis Brucker McCullough, M.D., Mansfield; Creighton University School of Medicine, Omaha, Nebraska, 1936; aged 40; died June 21; member of the Ohio State Medical Association and the American Medical Association. Dr. McCullough was secretary of the Richland County Medical Society in 1945, and was serving as its vice-president at the time of his death. He had served as Richland County coroner for the past five years except for several months spent in the Army Medical Corps. He had practiced in Mansfield since and was a member of the Presbyterian Church, Kiwanis Club, and the American Legion. Surviving are his widow and two daughters.

Edwin Herman Rea, M.D., Lisbon; University of Wooster Medical Department, Cleveland, 1896; aged 80; died June 15; former member of the Ohio State Medical Association and the American Medical Association. Dr. Rea was vice-president of the Jefferson County Medical Society in 1927. He was retired from practice. A son survives.

James William Reason, M.D., Hilliard; Starling Medical College, Columbus, 1895; aged 77; died June 27; member of the Ohio State Medical Association and the American Medical Association. Dr. Reason celebrated his 50th anniversary as a practicing physician in Franklin County a year ago. He had served on the Hilliard School Board for 48 years and as its president for the past 35 years. He was serving his second term on the Franklin County School Board. He was past master of the local Masonic Lodge, vice-president of the Farmers Bank of Hilliard, and a member of the Methodist Church. Surviving

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are a foster-daughter, Dr. Jessie Jasper of Columbus, and one brother.

Frank Frederick Schmidt, M.D., Columbus; Ohio State University College of Medicine, 1921; aged 50; died June 17. A native of Wapakoneta, Dr. Schmidt had practiced medicine in Columbus for 25 years. He was a member of the Masonic Lodge. Surviving are a son and a sister.

Ellsworth Sheldon, M.D., Fostoria; Starling Medical College, Columbus, 1903; aged 68; died June 10; former member of the Ohio State Medical Association and the American Medical Association. Dr. Sheldon practiced at Houcktown and Bloomdale, Ohio, before entering the Army Medical Corps in World War I. Following the war he located in Fostoria, where he practiced for 27 years. He was a member of the Methodist Church. Surviving are his widow, two daughters, and two sons, including Dr. C. C. Sheldon of Port Clinton.

William Burnett Weaver, M.D., Miamisburg; Medical College of Ohio, Cincinnati, 1900; aged 71; died May 18; member of the Ohio State Medical Association and Fellow of the American Medical Association. Dr. Weaver had studied in Berlin and Vienna prior to opening his office in Miamisburg about 40 years ago. Previous to his trip abroad, he had practiced for a time in Cincinnati. He was a member of the Catholic Church and the Knights of Columbus. Surviving are his widow and a sister.

Excellent Eighth District Meeting Held at Granville Inn

Approximately 60 physicians met at Granville, July 16, for the Mid-Summer meeting of the Eighth Councilor District of the Ohio State Medical Association. After luncheon at the Granville Inn, the following scientific program was presented by three members of the faculty of the Ohio State University College of Medicine:

"Cardiovascular Disease", Dr. George I. Nelson, professor of medicine; "'Practical Female Endocrinology", Dr. P. J. Reel, professor of gynecology; "Diseases of the Superficial Vascular Systems", Dr. George B. Watson, of the Department of Medicine.

Arrangements for the meeting were made by the District Society officers, Dr. R. W. Miller, Hemlock, president; Dr. H. F. Minshull, New Lexington, secretary; and Dr. Arthur J. Tronstein, Newark, Councilor. Charles S. Nelson, Executive Secretary of the Ohio State Medical Association, attended the meeting.

New officers of the Society are: Dr. A. C. Ormond, Zanesville, president, and Dr. Fred W. Phillips, Zanesville, secretary.

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ACTIVITIES OF COUNTY SOCIETIES

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

CLINTON

At the regular meeting of the Clinton County Medical Society, July 2, in Wilmington, a committee was named to work with the Woman's Field Army for Cancer Control. Guest speaker was Dr. William L. Wead, of Sabina, whose subject was "Medical Emergencies".—R. W. DeCrow, M.D., secy.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

CLARK

The month of June marks the first appearance of the new *Clark County Medical Society Journal*, official publication of the Clark County Medical Society. The publication committee includes Dr. Howard H. Ingling, chairman; Dr. Ray M. Turner, Dr. Will Ultes, and Dr. G. M. Lane. Mr. Frank C. Bateman is business manager.

At the June 20 meeting of the society, Dr. William D. Beasley, Springfield, recently returned from military service, presented a paper on "Differential Diagnosis and Therapy of Toxemias of Late Pregnancy". The meeting was held at the Hotel Shawnee in Springfield. The next session of the organization will take place September 19.—Bulletin.

MONTGOMERY

The general practice section of the Montgomery County Medical Society held a picnic July 17. The committee in charge included: Dr. A. S. Horwitz, Dr. Louis Loeber, Dr. Gordon Erbaugh, Dr. Rudolph Caplan, and Dr. J. K. Bailey.—News Clipping.

PREBLE

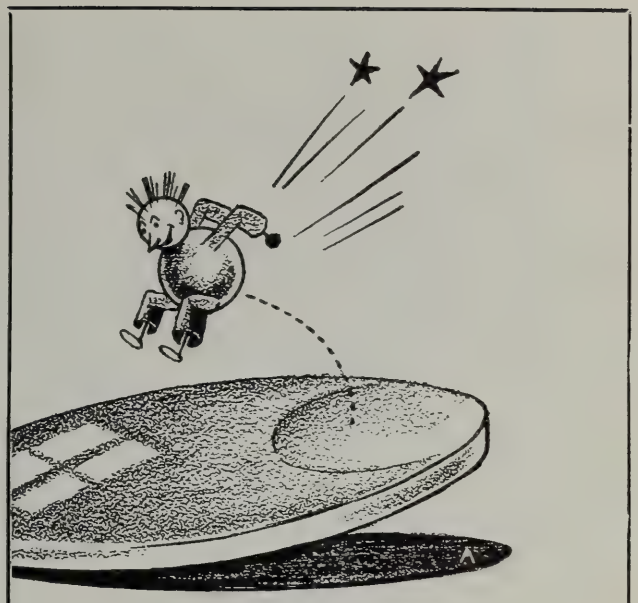
Dr. Harry Nieman, Dayton, addressed the Preble County Medical Society at the June 6 meeting of the group in the courthouse at Eaton.—News Clipping.

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

GEAUGA

Treatment of tropical diseases among returned veterans who contracted the ailments while in the service was discussed at the meeting of the Geauga County Medical Society June 5 by Dr. Alton Behm of Chardon, who recently returned from military service. Dr. Isa Teed Cramton announced that she is preparing the section on physicians for a history of Geauga County. The



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meeting was held at the home of Dr. and Mrs. W. C. Corey in Chardon.—News Clipping.

Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

BELMONT

Dr. W. Miles Garrison of the Belmont Sanatorium, St. Clairsville, is the new secretary-treasurer of the Belmont County Medical Society.

Eighth District

(COUNCILOR: ARTHUR J. TRONSTEIN, M.D., NEWARK)

GUERNSEY

At the June 6 meeting of the Guernsey County Medical Society, Dr. Arthur T. Hopwood, new superintendent of the Cambridge State Hospital, spoke on "The Clinical Aspects of Mental Illness".—M. S. Lawrence, M.D., secy.

WOMAN'S AUXILIARY NEWS

BY MRS. FRED W. BROSIUS, MIDDLETOWN
Chairman, Publicity Committee

GUERNSEY

A Woman's Auxiliary to the Guernsey County Medical Society was organized June 6 at the Berwick Hotel in Cambridge. Mrs. James A. L. Toland of Cambridge was elected president.

Other officers named were: Mrs. Thomas Frame, Byesville, vice-president; Mrs. Reo M. Swan, Cambridge, president-elect; Mrs. Ben Gillespie, Senecaville, recording secretary; Mrs. F. Gordon Lawyer, Cambridge, treasurer; and Mrs. Jack D. Knapp, Cambridge, publicity chairman. Mrs. T. R. Mattocks, director of the Eighth District of the Woman's Auxiliary to the Ohio State Medical Association was guest speaker at the July 18 meeting of the auxiliary, at Cambridge.

MARION

A dessert luncheon held at the home of Mrs. Carl W. Sawyer of White Oaks Farm, Marion, on June 11 closed the season for the Woman's Auxiliary to the Marion Academy of Medicine. Mrs. Clare W. Smith, Marion, who will serve as president next year, named her committees and for the program hour Mrs. C. W. Weber reviewed the book, "Wheels in His Head". Committee chairmen are: Mrs. H. K. Mouser, program; Mrs. Carl Leffler, publicity; Mrs. J. A. Dodd, public relations; Mrs. J. A. McNamara, membership; Mrs. J. W. Bull, Hygeia; Mrs. Clovis Altmaier, social; Mrs. C. G. Smith, historian; Mrs. Frederick T. Merchant, Mrs. F. L. Thomas, and Mrs. J. W. Jolley, finance. Officers are: Mrs. Richard Morgan, vice-president; Mrs. Jack Smyth, recording secretary; Mrs. C. W. Weber, corresponding secretary; and Mrs. A. E. Morrison, treasurer.

SCIOTO

Marking the last meeting until fall, the Woman's Auxiliary to the Hempstead Academy

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One week course in Surgery of the Colon and Rectum starting September 16, October 14.

One week course in Thoracic Surgery starting September 23.

GYNECOLOGY — Two weeks intensive course starting October 21.

One week personal course in Vaginal Approach to Pelvic Surgery starting September 16, October 21.

MEDICINE—Two weeks intensive course starting September 23, October 21.

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TEACHING FACULTY — ATTENDING STAFF OF COOK COUNTY HOSPITAL

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of Medicine was entertained June 12 at the home of Mrs. Carl G. Braunlin in Portsmouth.

Members who had been with their husbands while they were in the armed services related their experiences in various parts of the country at army posts and naval bases. Mrs. S. L. Meltzer served as moderator.

Buckeye News Notes

Bellaire—Dr. David M. Creamer, recently returned from the service, has been appointed to the Bellaire Board of Education. He was the Bellaire High School team physician before entering the armed forces.

Mansfield—Dr. D. C. Lavender has been appointed coroner of Richland County to fill the unexpired term of the late Dr. L. B. McCullough. Dr. Lavender was assistant coroner for eight years.

Circleville—Dr. George W. Heffner has begun his fifty-first year in the practice of medicine in Circleville.

Toledo—Dr. A. A. Brindley, Fourth District Councilor of the Ohio State Medical Association, spoke on the Wagner-Murray-Dingell Bill at the June 19 meeting of the South Toledo Exchange Club.

Manchester—Dr. E. S. Jones, who has been associated with the Veterans Administration for a number of years, recently indicated that he would establish practice in Manchester, Adams County.

Chillicothe—Dr. Else Klein, formerly of South Bend, Indiana, has been named superintendent of the Mt. Logan Tuberculosis Sanatorium.

Lebanon—Dr. Arch D. Harvey has been appointed for a two-year term as health commissioner of Warren County.

Kenton—Work was scheduled to begin in July on the Hardin Memorial Hospital, which will be located in Kenton. In ceremonies held at the building site county coroner Dr. John A. Mooney turned the first spade of earth for the project.

Hicksville—Dr. Forder F. DeMuth resigned his position as Defiance County Health Commissioner.

Fremont—Following a joint meeting of the Wood and Sandusky county health boards, Dr. F. M. Teeple, full-time health commissioner of Sandusky County since 1942, has been appointed also as health commissioner of Wood County. He succeeds Dr. H. J. Powell who retired recently after being health commissioner of Wood County for 26 years.

Mt. Vernon—Dr. Charles B. Tramont denounced federal plans for the socialization of medicine at a meeting of the Lions Club.

W. H. MILLER, M. D.

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FOR SALE: New Eye, Ear, Nose, and Throat Diagnostic Sets. Consists of opthalmoscope, retinascope, otoscope with three specula, illuminated tongue depressor holder, otoscope insufflator, two laryngeal mirrors, battery case handle, spare bulbs and electric cord set for use with transformer. Complete set is furnished in imitation leather case. This set was made for U. S. Army by National Electric Instrument Co. New and in original package to be sold below one-half price. Kent Optical Service, 75 Public Square, Lima, Ohio.

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Air Ambulance Service Provided By Columbus Company

Comet Air Line, Inc., a Columbus air cargo transportation firm operating out of Port Columbus, has announced that it is equipped to provide air ambulance service. The firm has a plane fully equipped to handle stretcher patients or a hospital cart, along with necessary attendants and equipment. The price for the service is 29 cents per mile round trip or 50 cents per mile one way. This includes patient, equipment, and as many as five attendants.

The plane used is a Canadian-made "Norseman" designated by the U. S. Army as a C-64. It is a dependable craft powered by a 650 H.P. Pratt-Whitney engine, with a cruising speed of 140 M.P.H. and its non-stop range is 1,000 miles.

William J. Meyer, president of the air line, does the piloting of the air ambulance. Meyer has had 13 years' flying experience under a commercial license. He has a high instrument rating with nearly 4,000 hours of flying time. For three and one-half years he was a test pilot for the Curtiss-Wright Corporation.

Physicians who may wish to take advantage of this opportunity to transport patients should contact Mr. Meyer at Port Columbus.

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The Ohio State Medical Journal

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JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.*

GEORGE H. SAVILLE, *Asst. Managing Editor*

HART F. PAGE, *News Editor*

The Surgical Treatment of Hypertension

EDWARD W. SHANNON, M.D.

THE importance of hypertension as a problem of health needs to be emphasized. Cardiovascular renal disease with hypertension as its dominant symptom stands first in the mortality rate today. It is responsible for more than one-half million deaths annually and causes more than one-half the deaths of persons over 45 years. After 45 the death rate from cardiovascular disease is 4 times that of cancer and 20 times that of either tuberculosis or diabetes. Hypertension also endangers the lives of a younger age group as well as those over 45. Physicians often appear to be misled as to the seriousness of hypertension by observing a hypertensive who lives an unusually long life. It is not at all unusual to obtain a familial history in which the grandparent dies of a "stroke" at 70, the mother of "Bright's disease" at 56, and the daughter is seriously ill with hypertension at 33.

The Author

• Dr. Shannon, Cleveland, is a graduate of Western Reserve University School of Medicine, Cleveland, 1941; and visiting neurosurgeon, St. Vincent's Charity, St. Alexis, St. John's, Fairview Park, Lakewood, and Cleveland State Hospitals.

THE MEDICAL TREATMENT

The fact that there are so many forms of medical treatment for hypertension suggests the ineffectuality of any single one. Sedation and rest is one of the most common forms of treatment. The importance of weight reduction in the obese patient is obvious, but this gives only some symptomatic relief and does nothing to reduce the pressure.

Thiocyanate therapy introduced by Pauli in 1903 gives favorable results in many cases. Some clinicians believe that a trial on thiocyanate therapy is justifiable in all hypertensives who do not exhibit specific contraindications. Patients over 60, those with severe cerebral or generalized arteriosclerosis, malignant hypertension, or hypertension of pregnancy, and angina pectoris do not respond favorably to thiocyanate treatment.

The low protein rice diet of Kempner has many advocates, but in reviewing this work Taylor and Page[1] found little value in it.

Most men who treat hypertensives are dissatisfied with the therapeutic measures available to them. Allen[2] has even said that the medical treatment of hypertension today is roughly comparable to the treatment of pernicious anemia before the use of liver extract. The medical treatment today is much the same as that outlined 30 years ago by Elliot and during the interval several million people have died either directly or indirectly of hypertension.

I believe that it is fair to say at this time the medical treatment of hypertension is unsatisfactory. It is hoped that before long, Page and his group may change this pessimistic outlook with their work on kidney extracts.

SURGICAL TREATMENT

The surgical treatment of hypertension was first suggested by Bruning in 1923 and Piere[3] in 1926. However, these Europeans did little to advance this type of treatment. Full credit for

Submitted February 6, 1946.

development of the surgical treatment of hypertension on a sound basis must be given to the teams of Adson and Craig, Peet and Smithwick.

Sympathectomy for hypertension in man has developed on a rather empirical basis as there is little experimental work on which to base its foundation. The surgical approach is based on the role which the autonomic nervous system plays in the peripheral vascular disease. By an extensive enough sympathectomy it is possible to denervate the vasomotor fibres going to the great splanchnic bed, kidneys, adrenals and lower extremities. Hines and Brown[4] believe that subjects with essential hypertension are usually constitutionally adequate types exhibiting psychic hyperirritability with evidence of increased influence of the sympathetic nervous system. These same men point out that the aboriginal negro does not have hypertension but that in the first and second generations of transplanted negroes hypertension is common and often more severe than among native whites.

Adson and Brown[5] in 1934 reported two cases of hypertension in which they had performed a laminectomy from L 6 to L 2 inclusive with section of the corresponding anterior roots. The results in these two cases were fair. Hever and Page[6,7] duplicated the results with the same procedure but this operation has been given up as similar results can be obtained by the Smithwick procedure which entails less serious complications.

Adson and Craig[8,9] subsequently developed a subdiaphragmatic approach in which they remove the first and second lumbar ganglia and section the greater splanchnic nerve where it enters the celiac ganglion. In 1940, Allen and Adson[2] reported their results in 224 patients. They classified their results as good in 13 per cent, fair in 18 per cent, and temporary in 39 per cent. It is evident that only 31 per cent had permanent results in so far as lowering of the blood pressure is concerned. A very much higher per cent, however, obtained symtomatic relief.

Peet, in 1935,[10] suggested the supradiaphragmatic approach with removal of the 10th, 11th, and 12th thoracic ganglia and section of the greater splanchnic nerve. In 1940, Peet, Wood, and Braden[11] reported the results of this procedure on 350 patients that had been followed from 9 months to 7 years. The results are:

Blood Pressure—	
Reduced to normal	11.7%
Markedly reduced (but not normal)	7.6%
Total significantly reduced	51.4%
General Disability—	
Symptoms improved	86.6%
Eye Grounds—	
Disappearance of papilledema when present	73.8%
Total cases with improvement	69.4%
Heart—	
Size reduced	64.0%
E.K.G. improved	53.4%
Renal Function—	
Urea clearance improved	52.2%
Urine concentration improved	44.8%

Smithwick performed the procedures previously described. He found that in many cases unsuccessful results could be converted into successful ones by a more extensive denervation of the sympathetic nervous system. Smithwick points out that the best results are obtained in sympathetic surgery when the operation is adequately complete, preganglionic in type and extensive enough to guard against future regeneration of the interrupted pathways. In addition to the above requirements an operation for hypertension should allow the operator to explore the kidneys, adrenal glands, and the paravertebral region. Smithwick[12] developed the operation of lumbodorsal splanchnicectomy which meets all of the above requirements. This operation is performed in two stages, one side being done about ten days after the other. The sympathetic chain is removed from D 8 or 9 to L 1 or 2 inclusive and the greater splanchnic nerve is sectioned at the celiac ganglion and then avulsed from high in the chest.

In 1944, Smithwick[13] reported on a series of 156 hypertensives who had been followed from 1 to 5 years. He classified his results, based upon the fall in diastolic pressure, into 5 groups. In Group 1 there was a lowering of 30 mm. of Hg. or more; in Group 2 of 20 to 29 mm. Hg.; in Group 3 of 10 to 20 mm.; in Group 4 up to 10 mm. Hg.; and in Group 5 the blood pressure was higher. The average reductions for the first 4 groups respectively were 61/43, 44/24, 27/15, 10/5. The results in Groups 1 and 2 were regarded as significant and of Group 3 as probably significant. The results were as follows:

Group 1	41.0%		
Group 2	20.5%	61.5%	
Group 3	17.9%		79.4%
Group 4	10.9%		
Group 5	9.7%		

In 147 patients who had abnormal eye grounds, 51 per cent showed improvement, 5 per cent became worse, and 44 per cent remained unchanged.

Of the 82 patients with abnormal E.K.G., 63.5 per cent showed improvement, 5.9 per cent became worse, and 30.6 remained unchanged.

Disappearance of albuminuria, return toward a normal urinary sediment, and improvement in ability to concentrate the urine and to excrete the dye were noted in the great majority of cases.

It may be of some significance that even in the Groups 4 and 5 results, 48.2 per cent showed improvement in the eye grounds, 55.9 per cent showed improved E.K.G., and 44.4 per cent revealed improved renal function, suggesting that

even though there was no fall in the blood pressure the progression of the disease may have been retarded.

The old belief that a reduction in blood pressure is followed by harmful effects is clearly refuted in these operative cases by the appearance of favorable eye ground changes, improvement in E.K.G. and kidney function as well as symtomatic improvement of the patient.

Castleman and Smithwick [14] reported a series of renal biopsy obtained from 100 hypertensive patients who had a lumbodorsal splanchnicectomy. The biopsies were graded according to the vascular disease present without any knowledge of the clinical data.

It was found that there were enough differences to classify the specimens into 5 groups, grades 0, 1, 2, 3, and 4. This classification was based on the work of Moritz and Oldt.[15] Seven per cent were grade 0; 21 per cent grade 1; 25 per cent grade 2; 33 per cent grade 3; and 14 per cent grade 4. Upon these findings the conclusion was drawn, "That morphologic evidence of renal vascular disease in more than one-half the cases was inadequate to be the sole factor in producing the hypertension and that in many of these and probably others the hypertensive state antedated the renal vascular lesion, which once established, probably aggravated the hypertension. These observations were not in keeping with the concept that renal ischemia due to pre-existing renal vascular disease is the cause of hypertension in man."

It is clear that the results of the operation vary and therefore the importance of selecting suitable candidates is obvious. The sex, age, degree of hypertension, renal function and response to sedation are all factors having some bearing on the end results.

SELECTION

Candidates for this operation are hospitalized for several days and the following routine carried out. The patients are put at bed rest and their blood pressure taken by nurses three times a day so that some idea as to the basic level may be obtained. Several urine analyses are run, a urine concentration test, a P.S.P. test, an intravenous pyelogram, and a seven foot heart are made. The eye grounds are carefully evaluated and graded. Grade 1 includes eye grounds with any variations from the normal except arteriovenous compression, hemorrhage, exudate and papilledema. Grade 2 eyes are those with arteriovenous compression but without hemorrhage, exudate or papilledema. Grade 3 eye grounds include hemorrhage and exudate but no papilledema. Grade 4 eye grounds are those which have papilledema.

A sedation test is performed by giving the patient 0.2 gm. of sodium amytal at 7, 8, and 9:00 P. M. and hourly blood pressure readings taken for 12 hours. A postural and cold pressor test is carried out, based on the work of Hines and Brown. [4, 16] Blood pressure and pulse readings are taken every minute for five consecutive minutes with the patient first lying, then sitting, and finally standing. The patient is then placed flat in bed and five more readings taken. One hand is then immersed in ice water for one minute after which readings of both blood pressure and pulse are recorded for five consecutive minutes.

Hines and Brown[4] have shown that 98 per cent of hypertensives react to this cold pressor test by an increase in systolic pressure of 20 mm. or more and the diastolic increases 15 mm. or more. Only 15 per cent of people with normal blood pressure react in this way and such hyperreactors are considered to be prehypertensives.

PULSE PRESSURE

Smithwick has graded the hypertensives into 3 types based on their pulse pressure. Type I are those in which the pulse pressure is less than one half the diastolic pressure, Type II those in whom the pulse pressure is equal to or up to 19 mm. more than one-half of the diastolic pressure, and Type III are those in which the pulse pressure is 20 mm. or more than one-half the diastolic. This typing is based on the average readings with the patient in the recumbent position during the postural test.

In Smithwick's[13] series 81.8 per cent of Type I women have had group 1 or 2 results and 96.8 per cent fell into groups 1, 2 or 3. In men with Type I hypertension, 61.7 per cent have had group 1 or 2 results and 76.5 per cent have fallen into either 1, 2 or 3 group results.

In women with Type II hypertension, 71.4 per cent have had group 1 or 2 results with an additional 6 per cent having a group 3 result. Type II men have had group 1 or 2 results in 50 per cent with an additional 25 per cent falling in group 3.

Type III hypertensives did poorest of all. Of the women 47.8 per cent had group 1 or 2 results and 80. per cent fell into the first 3 groups. Men with this type of hypertension did poorly as only 23.2 per cent had either a group 1 or 2 results and 53.8 per cent fell into the group 1, 2 or 3 results.

The response to the sedation test is of some prognostic value. The lowest reading obtained is taken as maximum response to sedation; 88.5 per cent of those whose diastolic pressure fell to 90 mm. Hg. or less had group 1, 2 or 3 results.

The state of the eye grounds also is important. The results for 88.5 per cent of patients with grade 1 eye grounds, 77.2 per cent with grade 2, 69.1 per cent with grade 3, and 83.3 per cent

with grade 4 eye grounds had results which fell into either group 1, 2 or 3 results.

Sex is important as 84.8 of all women had results in groups 1, 2 or 3 whereas only 71.8 per cent of the men had similar results.

Postoperatively these patients usually have a postural hypotension which may be troublesome for several months. This is combated by having the patient wear Ace bandages around their legs and thighs and a tight abdominal support. Physiologically this is a desirable reaction even though it is troublesome to the patient. Over a period of several months, however, this condition clears up so that it is no longer necessary to wear supports. Intercostal neuralgia is another troublesome postoperative complication but this too subsides after a few weeks. In males impotence may follow the operation if the second lumbar ganglion is removed on both sides.

MECHANISM

The mechanism by which lumbodorsal splanchnicectomy relieves hypertension is as yet not clear. The following explanations have been given. By denervating the kidney the renal blood flow is improved. Renal ischemia, however, is not uniformly present and it has been found that denervation of the kidney alone is not effective. By releasing the neurogenic impulses to the smooth muscle in the vessels the peripheral resistance is decreased and consequently there is a fall in the blood pressure. This is not the full explanation, however, as blood volume rapidly adjusts to the space in which it has to circulate. Pooling of the blood in the splanchnic area would seemingly result in congestion and digestive disorders but such does not occur. Another explanation is that there is an inadequate venous return to the heart. This explains the tachycardia and dyspnea which occur on assuming the upright position but does not take into consideration the fall in blood pressure which remains after the postural hypotension disappears. Possibly the effect is due to a combination of the above factors. At this time no one knows the exact explanation as to why the Smithwick operation causes a fall in blood pressure in hypertensives.

The question is frequently asked, will the fall in blood pressure be permanent? The only answer to this is that some of the patients have been followed for over seven years and those who had a good result after one year had the same result several years later. This question however will be answered only by the observation of these patients over a long period.

Another question is whether pregnancy will interfere with the results of the operation. In answer to this it is interesting that many of Smithwick's patients have had a normal pregnancy with no untoward results from child birth following a lumbodorsal splanchnicectomy.

The objection is frequently raised that the fall in blood pressure following the operation is not due to any specific effects from the operation but rather merely the non-specific effect which is often seen following surgery for an unrelated condition.[17,18] Rojas, Smithwick and White[19] compared the results in 100 cases of lumbodorsal splanchnicectomy with 100 non-specific operations in hypertensives and showed that there was a great difference in favor of splanchnicectomy. Page[20,21] also reached this same conclusion.

Of the various operative procedures mentioned, the Smithwick operation gives a higher per centage of good results than the others. Page and Corcoran[21] in their book on hypertension conclude that the Smithwick procedure is the operation of choice. De Takas[22] has also reached the same conclusion after trying the various procedures.

BIBLIOGRAPHY

1. Personal communication.
2. Allen, E. V., and Adson, A. W.: Treatment of Hypertension; Medical versus Surgical. Ann. Int. Med:. 14:288-307, Aug., 1940.
3. Piere, G.: La Resezione dei Nervi Splanchnici. Ann. Ital. di Chir., 6,678, July, 1927.
4. Hines, E. A., Jr. and Brown, G. E.: Standard Test for Measuring Variability of Blood Pressure: Its Significance as Index of Prehypertensive State. Ann. Int. Med., 7,209-217, Aug., 1933.
5. Adson, A. W., and Brown, G. E.: Malignant Hypertension; Report of Case Treated by Bilateral Section of Anterior Spinal Roots from Sixth Thoracic to Second Lumbar Inclusive. J.A.M.A., 102, 1115-1118, April, 1934.
6. Page, I. H., and Heuer, G. J.: Treatment of Essential and Malignant Hypertension by Section of Anterior Nerve Roots. Arch. Int. Med., 59, 245-298, Feb., 1937.
7. Page, I. H., and Heuer, G. J.: Effects of Splanchnic Nerve Resection on Patients Suffering from Hypertension. Am. Jr. M. Sc.; 193, 820-841, June, 1937.
8. Craig, W. McK., and Brown, G. E.: Resection of the Splanchnic Nerve in Cases of Hypertension. Proc. Staff Meet. Mayo Clin., 8,373, 1933.
9. Craig, W. McK., and Brown, G. E.: Unilateral and Bilateral Resection of the Major and Minor Splanchnic Nerves. Arch. Int. Med., 54,577, Oct., 1934.
10. Peet, M. M.: Splanchnic Section for Hypertension Preliminary Report. Univ. Hosp. Bull., Ann Arbor, 1:17-18, June, 1935.
11. Peet, M. M., Wood, W. W., and Braden, S.: The Surgical Treatment of Hypertension. J.A.M.A., 115,1875, 1940.
12. Smithwick, R. H.: Technique for Splanchnic Resection for Hypertension; Preliminary Report. Surgery, 7, 1-8, Jan., 1940.
13. Smithwick, R. H.: Surgical Treatment of Hypertension. Arch. Surg., 49, 180-192, Sept., 1944.
14. Castleman, B., and Smithwick, R. H.: The Relation of Vascular Disease to the Hypertensive State. J.A.M.A., 121, 1256-1261, April, 1943.
15. Maritz, A. R., and Oldt, M. R.: Arteriolar Sclerosis in Hypertensive and Non-Hypertensive Individuals. Am. Jr. Path., 13:679-728, Sept., 1937.
16. Hines, E. A. Jr., and Brown G. E.: Standard Stimulus for Measuring Vasomotor Reactions: Its Application in Study of Hypertension. Proc. Staff Meet. Mayo Clin., 7, 332-335, June, 1932.
17. Volini, I. F., and Flaxman, N.: The Effects of Nonspecific Operations in Essential Hypertension. J.A.M.A., 112, 2126, May, 1939.
18. Adamson, J. O., and Dubo, S.: The Effect of Surgical Operations in Blood Pressure. Canad. M. A. J., 49, 161, Sept., 1943.
19. Rojas, F., Smithwick, R. H., and White, P. D.: Nonspecific Major Operations and Lumbodorsal Sympathectomy, A Comparison between Their Effects of the Blood Pressure. J.A.M.A., 126:15, Sept., 1944.
20. Page, I. H.: Medical Aspects of Surgical Treatment of Hypertension. J. A. M. A. 110, 1161-1165, April, 1938.
21. Page, I. H., and Corcoran, A. C.: Arterial Hypertension. Year Book Publishers, Chicago, 1945.
22. De Takats, G., and Heyer, H. F., and Keeton, R. W.: The Surgical Approach to Hypertension. J.A.M.A., 118, 501-507, Feb., 1942.

Orthostatic Hypotension: Its Occurrence in Dermatology

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WHEN blood pressures are taken in lying, sitting, and standing positions, the systolic and diastolic levels should remain constant.[1] With individuals in whom there is a drop in blood pressure readings in sitting, standing, or both positions, the condition is referred to as orthostatic hypotension. This is so considered whether the patient is the hypertensive, hypotensive, or normal type.

Theories behind the mechanism of orthostatic hypotension are numerous. Bradbury and Eggleston[2] believe that there is a deficiency in the function of the sympathetic nervous system. MacLean, Allen, and Magath[3] state that it may be due to inadequate return of venous blood to the heart. Hallock and Evans[4] mention that a decrease in blood volume is present and hemoconcentration takes place due to abnormal filtration. H. W. Smith[1] records that there is a normal relationship between the blood pressure and renal circulation. A factor in the production of orthostatic hypotension is the breaking up of this normal interdependence.

T. M. Durant[5] reminds us that postural hypotension is not a disease entity. He considers patients with this condition to be linear in build, usually underweight, nervous, unstable, and habitually hypothermic. They show symptoms of dizziness, headaches, lack of stamina, and cold extremities. By correcting the weight, using graduated exercises and dietary measures, he has been able to alleviate the symptoms, but although these disappear, the blood pressures show no changes. Other complaints include: insufficient sweating, exacerbation of symptoms in the early morning and during hot baths, and polyuria. Certain drugs (see below) may alter the orthostatic condition, but the syncope, dizziness, blurred vision, nervous instability, hypothermia, and asthenia still persist.

DeTakats, et al.,[6] found that postural hypotension after extensive splanchnic nerve section and lumbar sympathectomy produced improvement of renal function with pronounced polyuria. The use of vasoconstrictors had only a temporary benefit.

Of 978 dermatological cases checked in my office (see table below), 412 showed a drop in pressure when readings were taken in the three positions referred to above. (In 96 of the 412 patients, blood pressures not only dropped when the patients sat, but went even lower when they stood.) One hundred forty-one cases in the original group showed no fluctuation in blood pressure, while the remaining 425 showed a rise in pressure while changing in the three aforementioned positions. Although some authorities consider that the systolic and diastolic pressures should remain constant in normal individuals, it is interesting to note that I found 14.4 per cent (141 out of the 978) showed no fluctuation, while 43.4 per cent (or 425 out of the total) evidences rises in succeeding positions; 20.1 per cent of these 425 showed normal changes from recumbent to sitting positions, but remained unchanged for the upright position.

In this series, 117 had diastolic and 147 had systolic hypotension, while 66 had diastolic hypertension and 95 had systolic hypertension. A peculiar phenomenon had occurred; 14 patients, while standing, had inaudible blood pressures. Repetition of the readings on different days produced the same results. In other cases, occasionally, the systolic or sometimes the diastolic pressures were not audible, but in these particular 14 individuals, neither pressures were ever audible.

In the group of 978 referred to above, high pulse pressures of 50 and over occurred in 49 cases, and low pulse pressures (under 30) were present in 20 individuals.

Pulse records were kept on each patient in each position. No increase in pulse rate occurred in 38 patients, while 59 actually showed an orthostatic pulse drop.

The most severe lowering of blood pressures was found in a 49-year old woman, going through menopause. She also had diabetes, varicose eczema, and ulcer. The records showed the following readings: 190/100, 150/100, 124/90.

Corcoran, Browning, and Page[7] employed angiotonin and head-up bed in postural changes on arterial pressure. The angiotonin produced characteristic pressor and renal vasoconstriction effects, and caused renal ischemia. Effec-

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TABLE

DIAGNOSIS	No. of Patients	Hypotension		Hypertension		B. P. Orthostatic in 3rd Position	B. P. — No Changes	B. P. Inaudible in 3rd Position	Orthostatic B. P. in 2nd. and 3rd Positions	Pulse, No Change	Pulse Drop	Pulse Pressure	
		Systolic	Diastolic	Systolic	Diastolic							High	Low
Acne Vulgaris	97	11	6	3	1	38	18	6	2	3	12	7	2
Acrocyanosis	1					1							
Alopecia Areata	10	4	2			4	3		1		1		
Asteatosis	5						2						
Atopic Dermatitis	30	3		3		8	3		4			1	1
Bath Pruritus	1					1							
Blepharitis	1						1						
Carbuncle	2						1						
Dermographia	2	1	1	1		1	1						
Drug Eruptions	2	1	1										
Eczema, Arms and Forearms	5			3	2	1	3		1		1	1	
Eczema, External Ears	5				1	1	1				1		
Eczema, Eyelids	14	1	1	2	1	7	2		2		2	1	
Eczema, Face	19	1	1	5	4	12	4		3		2	2	
Eczema, Feet	6	1	1			1	1		1				
Eczema, Generalized	62	12	10	5	5	25	4	1	6			2	1
Eczema, Hands	18	2	2	1	1	15			2		1		
Eczema, Fingers	42	8	10	6	3	18	7		3			2	1
Eczema, Legs	6			2	1	1	2		1			1	
Eczema, Lips	3					1			1				
Eczema, Neck	11			4	1	7	1					1	
Eczema, Nose	4				1	2	1						
Eczema, Scalp	2			1	1								
Erythema Multiforme	8	5	4			6			2				
Folliculitis	2						1						1
Furunculosis	2					1							
Granuloma Annulare	1						1						
Herpes Simplex	4	1	1			2	1				2		
Herpes Zoster	4	2	2			2							
Hyperidrosis	3					2					1		
Hypertrichosis	27	6	6	2	1	8	4		4	5	3		
Hydro-aestivale	1	1	1			1							
Ichthyosis	1	1	1										
Impetigo	3					1							
Keloid	2			1	1	2							
Keratosis	5	4	4			4							
Lentigo	3					3							
Leukoplakia	1					1							
Lichen Planus	7	3	3			5	1		1	1	2		1
Lupus Erythematosus	3	2	1			1							
Lupus Vulgaris	1			1	1		1					1	
Moles	3	1	1			1					1		
Nail Dystrophy	18		1	2		9	1	1	2	2	2		
Neurodermatitis	16			4	4	7	5	3	2	1	2		
Occupational Dermatitis	36		1	5	4	12	9	2	3	4		1	
Paronychia	9					2	1						
Pellagra	42	6	4	6	4	28			8	2	2	8	2
Pemphigus	1					1							
Pityriasis Rosea	12					2	1						2
Pruritus, Generalized	14		1	3	1		8		2		2	2	
Pruritus, Genitals	43	7	8		7	20	12		4	4	2	4	1
Pruritus Ani	22	1	3	3	3	12	5		1	3	2	2	
Psoriasis	34	18	9	3		20	6		2	2	2	2	1
Recalcitrant Vesicular Eruptions	78	10	11	12	8	32	14		15	4		2	4
Rosacea	6	1		3	3	3			1	1		1	
Seborrheic Dermatitis	76	6	4			22	6	1	4	2	6	6	2
Sycosis Vulgaris	4					1					1		
Syphilis, III	25	1	1	3	2	8	1		2		2	2	1
Tinea Pedis	18	3	2	4	2	2	1		2	3			
Tinea, Groin	6	2	1	1		1					2		
Tinea Versicolor	3					1							
Urticaria	17	3	2	1		11	4		2	1	1		
Varicose Eczema	26	2	2	2		13			6		3		
Verrucae	36	15	11	3	3	18			6		3		
Vitiligo	9	1				3	2						
Xanthelasma	2					2							

tive renal flow and arterial pressure decreased during syncope of postural hypotension. When angiotonin was injected at this time, there was an increase in renal flow and a rise in blood pressure. Both of these relieved the syncope.

MacLean and Allen[8] have corrected orthostatic hypotension by using the head-up bed.

Gregory[9] has seen a return to normal blood pressure with desoxycorticosterone in oil, and percorten pellets.

Other therapeutic measures included tight abdominal and leg binders, avoidance of strenuous exercise on warm days, and the use of ephedrine, benzedrine paredrine, paradrenal, and neosynephrin.

Urinary findings in postural hypotension show: white blood cells, albumin, and excess carbonates.

Of the varied diseases occurring in the cases under discussion, there was no uniformity in the basal metabolism readings or blood analyses. Fluctuations were found in levels of B.M.R., sugar, non-protein nitrogen, uric acid, sodium, potassium, calcium, phosphorus, phosphatase, sulfur, cholesterol, cholesterol esters, albumin, globulin, chlorides, vitamins A and C, and anemias. Dark adaptation tests and petechial reactions were recorded for all patients. Of this total, 621 had prolonged adaptation time and 265 had positive capillary fragility.

Employing the measures outlined by Durant (see above) as well as correcting the habits, blood components, and B.M.R., and using proper endocrines, the orthostatic hypotension was improved in a majority of the cases. Drops in blood pressure with its attendant symptoms, recurred when individuals deviated from these measures.

In summary, a group of 978 dermatological patients were studied for postural hypotension; 42.1 per cent showed a drop when positions were changed (from lying to sitting to standing); 14.4 per cent showed no fluctuations; and 43.4 per cent evidenced rises from the first to the third phase. Symptoms associated with this condition include dizziness, blurred vision, nervous instability, headaches, lack of stamina, and hypothermia. Not only are these alleviated, but blood pressure is improved when deficiencies, blood constituents, basal metabolism, endocrine imbalance, diet, and habits are corrected.

BIBLIOGRAPHY

1. Smith, H. W.: Physiology of Renal Circulation. Harvey Lectures, Baltimore, 1940-41.
2. Bradbury, S., and Eggleston, C.: Postural Hypotension; a Report of Three Cases. Am. Heart Jr., 1: 73, 1925, 3:105, 1927-28.
3. MacLean, A. R., Allen, E. V., and Magath, T. B.: Orthostatic Tachycardia and Orthostatic Hypotension; Defects in Return of Venous Blood to Heart. Am. Heart Jr., 27:145-163, Feb., 1944.
4. Hallock, Philip, and Evans, Gerald: Effects of Posture on Circulating Blood Volume in Case of Orthostatic Hypotension and Tachycardia. Proc. Soc. Exper. Biol. and Med., 47:460-463, June, 1941.
5. Durant, T. M.: Arterial Hypotension. Penn. Med. Jr., 45:1188-1191, Aug., 1942.
6. DeTakats, B., Heyer, H. E., and Keeton, R. W.: Surgical Approach to Hypertension. J.A.M.A., 118:501-507, Feb. 14, 1942.
7. Corcoran, A. C., Browning, J. S., and Page, I. H.: Renal Hemodynamics in Orthostatic Hypotension; Effect of Angiotonin and Head-Up Bed. J.A.M.A., 119:793-794, July 4, 1942.
8. MacLean, A. R., and Allen, E. V.: Orthostatic Hypotension and Orthostatic Tachycardia; Treatment with Head-Up Bed. J.A.M.A., 115:2162-2167, Dec. 21, 1940.
9. Gregory, R.: Treatment of Orthostatic Hypotension with Particular Reference to Use of Desoxycorticosterone. Am. Heart Jr., 29:246-252, Feb., 1945.

Brucellosis—Clinical Aspects

A mild anemia may be present but is not characteristic of the disease. The leukocyte count is often normal or slightly below normal, and a predominance of lymphocytes is a frequent finding. In contrast to most infectious diseases, in brucellosis the erythrocyte sedimentation rate is normal or only mildly increased. The presence of Brucella agglutinins in the blood serum is one of the most reliable findings. Difficulties arise in interpretation when the titre of agglutinins is low. It has been stated that a titre of 1:80 is diagnostic; however, it is known that early in the course of the disease agglutinins may be absent.

The complement-fixation test does not appear to have any material advantage over the agglutination test. The opsonocytophagic test advocated by Huddleson and others as a test of the immune status of the patient does not appear to be sufficiently reliable for routine clinical usage.

The only finding which can be said to be definitely diagnostic is the repeated isolation of viable Brucella from the blood, other body fluids or tissues. Since Brucella are notably difficult to culture, in the majority of cases one is unable to obtain such evidence. In 40 instances of brucellosis at the University of Minnesota Hospitals, positive cultures were obtained in only one-third.

Since skin allergy to Brucella develops early in the course of the disease the skin test is a useful method in clarifying the issue where the diagnosis is in doubt. Although purified Brucella protein antigens such as Brucellergen are probably most satisfactory for such purposes one may safely use 0.1 cc. commercial heat-killed Brucella vaccine intradermally after diluting it 1-100 with sterile physiological saline. The reaction is usually delayed; thus the test should be read in 24 and 48 hours. The skin test has the same significance as does the Mantoux test in tuberculosis. Thus a positive skin test may be expected in nearly every case of active brucellosis. However, a positive skin test is no more reliable than the finding of a low titre of serum agglutinins in deciding whether a given patient has active brucellosis. Skin allergy persists for years after clinical recovery from the disease. Except during the first few weeks, a negative skin test may be said to rule out brucellosis; an exception to this statement must be made in those rare instances where Brucella have localized on a heart valve. —Wendell H. Hall, M.D., Minneapolis; Minnesota Medicine, Vol. 29, No. 7, July, 1946.

Simultaneous Traumatic Dislocation of Both the Right Hip and the Right Knee Joint: A Case Report

PATRICK C. DORAN, M. D.

COMPLETE dislocation of the hip or of the knee joint is still an uncommon occurrence in spite of the increased hazards of ground and air transportation. This case, therefore, is offered as a rare resultant pattern of traumatic force, since it presents complete dislocations of the two major joints of the right femur, with the hip joint subluxation complicated by a fracture

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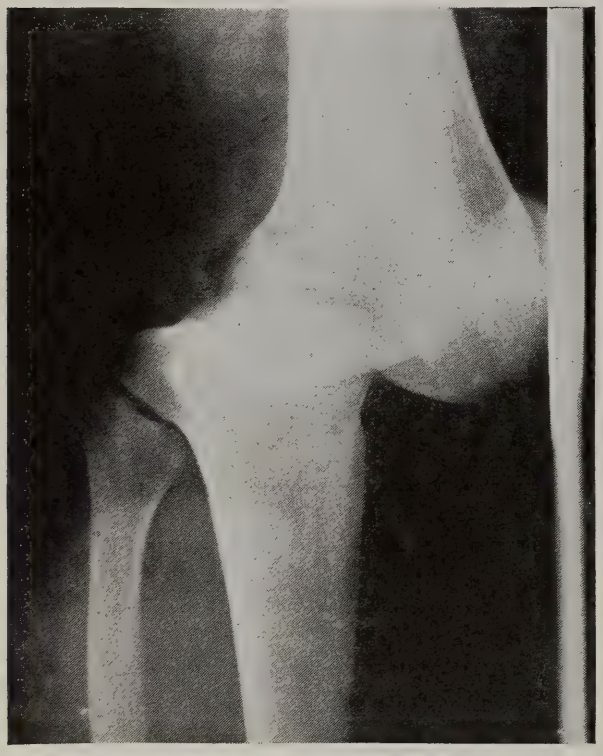


Fig. 1. Roentgenogram of the right knee joint dislocation.

of the posterosuperior rim of the acetabulum, and a fracture of the ilium.

The injury resulted from the collision of an automotive vehicle with a motorcycle. The cyclist, as is usually the case, was the victim. It is the usual experience in this type of accident to find that the lower leg receives the greatest damage. In this instance, however, the entire femur, intact, was ejected from its articular relationships.

The patient, a male, age 24 years, was seen first within the hour following his accident. He complained of pain in the right knee, only. He was conscious and cooperative. There was an obvious gross deformity in the right knee joint area which, clinically, appeared to be a lateral type dislocation (Fig. 1), fitting the class three category of Conwell's[3, 4] classification of knee joint dislocations. Soft tissue damage was minor. No vascular or neurological injury at, or distal to, the sites of dislocation was noted. At

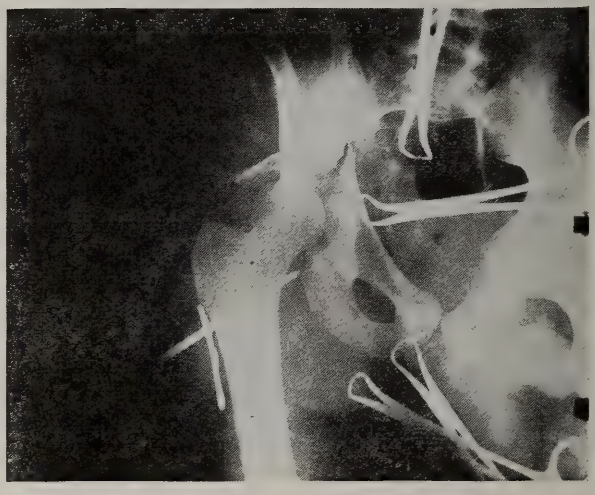


Fig. 2. Fracture-dislocation of the right hip. The first wood screw was inaccurately placed.



Fig. 3. Roentgenogram of wood screws in place and traction instituted. Dislocation is reduced, but the acetabular fragment is not.

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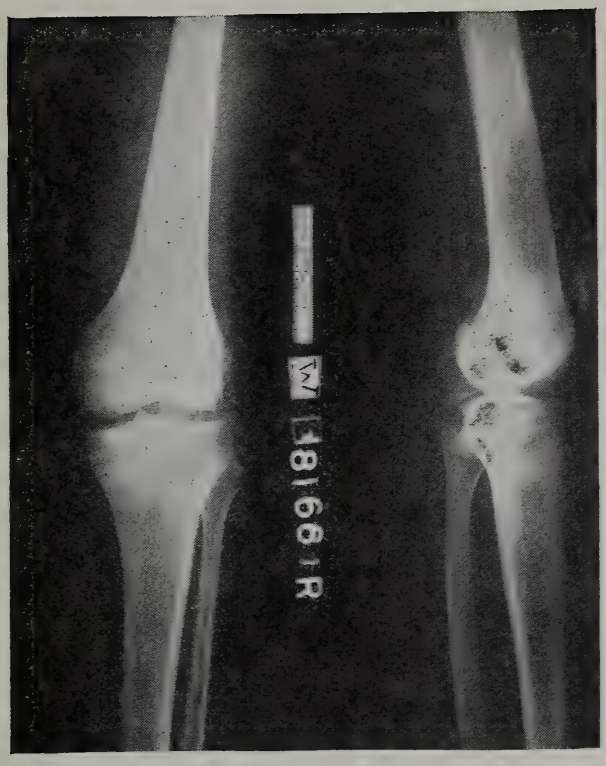


Fig. 4. Radiographic appearance of the right knee joint 22 months after reduction.



Fig. 5. A. P. view of the pelvis showing both hip joints. Acetabular fracture fragment has settled, but is not anotomical.

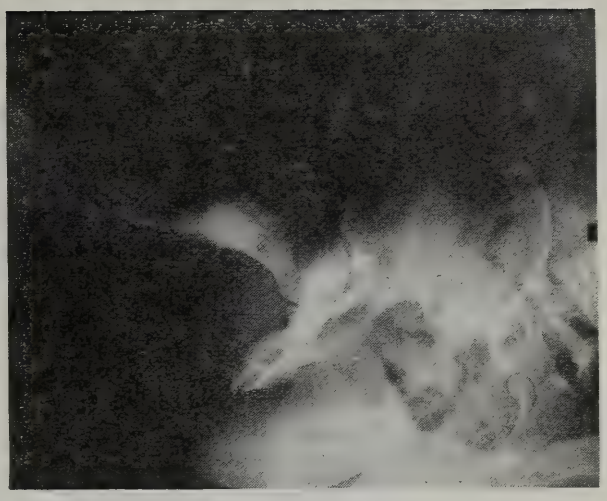


Fig. 6. Lateral roentgenogram, right hip joint.



Fig. 7. Right hip joint is stable clinically.

this time, injury of the right hip joint area was not diagnosed.

Reduction of the dislocated right knee joint was easily accomplished under general anesthesia. An attempt was made, with the patient anesthetized, to appraise the amount of damage to the ligaments of the joint. Then it was ascertained that disability existed in the hip joint area. X-ray films (Fig. 2) disclosed the illustrated deformity.

Skeletal traction was employed to reduce the fracture-dislocation. A Kirschner wire was placed through the right femur at a supracondylar level and two 4-inch length wood screws were inserted into the femoral neck (Fig 3). The knee was immobilized with the wire incorporated into the circular plaster of paris dressing, the cast extending from the upper third of the thigh to the toes. Balanced traction, applied in the axial and abduction planes, was utilized. Open reduction was anticipated.[8] Subsequent recheck films revealed satisfactory reposition of acetabular fragments and maintainance of reduction. This treatment was continued for eight weeks.

After the eighth week, immobilization and traction were discontinued. Vigorous quadriceps training, previously instituted, was accelerated. Weight bearing was permitted after 12 weeks. Clinical appraisal, 22 weeks post injury (Fig. 4, 5, 6, and 7), revealed normal hip joint motion. The movements of the knee joint, however, were restricted; motion range measuring 180 degrees

to 95 degrees. The right thigh had atrophy of one-half to one inch in circumference as contrasted with identical levels of the left thigh. The power of the right quadriceps, as compared with that of the left, was approximately 25 per cent diminished. The right knee joint capsule was thickened and, upon palpation, generalized crepitation was noted. The joint was stable in all directions.

The patient had no complaints other than inability to flex the right knee completely. It is felt that prognosis for functional improvement of this joint is not good.

BIBLIOGRAPHY

1. Balensweig, I.: Injuries of the Knee Joint. Surg. Clinics of North America, 497-519, April, 1943.
2. Clarke, Capt. H. O.: Dislocation of the Knee Joint with Capsular Interposition. Proc. Roy. Soc. Med., 35:759, Oct., 1942.
3. Conwell, H. E., Alldredge, R. H.: Complete Dislocation of the Knee Joint. Surg. Gynec. and Obst., 64:94-101, Jan., 1937.
4. Conwell, H. E.: Dislocation of the Knee Joint. Am. Jr. Surg., 43:492-96, Feb.
5. Cubbins, W. R., Callahan, J. J., Scuderi, C. S.: Dislocation of the Knee Joint and Their Complications. Indust. Med., 12:732-733, Nov., 1943.
6. Fitzgerald, F. P.: Reduction of Old-Standing Dislocation of the Knee Joint. Brit. Med. Jr., 2:542, Nov. 7, 1942.
7. Griesemer, W.: Complicated Traumatic Dislocations of the Hip. Am. Jr. Surg., 53:16-27, Jan., 1944.
8. King, D.: Fracture-Dislocations of the Hip Joint. Jr. Bone and Joint Surg., 23:533-551, July, 1941.
9. Okelberry, A. M.: Traumatic Dislocation of the Hip with Fracture of the Acetabulum. Rocky Mountain Med. Jr., 40:378-383, June, 1943.
10. Perry, A.: Common Dislocations of Knee and Long Bones of Lower Limb. Practitioner, 144:559-570, June, 1940.
11. Krida, A.: Dislocations of the Knee Joint with Special Reference to Accessory and After Treatment. Am. Jr. Surg., 50:534-535, Dec., 1940.
12. Pringle, H.: Traumatic Dislocation at the Hip Joint; An Experimental Study on the Cadaver. Glasgow, 1943.
13. Taylor, R. G.: Case of Bilateral Traumatic Dislocation of the Hips. Brit. Jr. Surg., 27:107, 1940.
14. Walker, W. A.: Traumatic Dislocations of the Hip Joint. Am. Jr. Surg., 50:545-549, Dec., 1940.
15. Whiston, G.: Bilateral Traumatic Dislocations of the Hip. Rocky Mountain Med. Jr., 41:319-320, May, 1944.
16. Wilson, M. J., and Michele, A. A., and Jacobson, E. W.: Complete Dislocation of the Knee Joint: A Report of Six Cases with End Results. Am. Jr. Surg., 52:77-81, April, 1941.
17. Wilson, M. J., and Cantwell, A. R.: Traumatic Dislocation of the Hip. Bull., New York Med. Coll., 4:189-190, Dec., 1941.

The problem of resistance to antibiotics is one which will increase in importance as does the therapeutic use of these agents. At present there appears to be a species difference in the ability of different bacteria to become resistant to the various antibiotics now in common use. Sulfonamide resistant strains of gonococci, streptococci, straphylococci, and dysentery bacilli have appeared. Pneumococci and meningococci apparently rarely exhibit this phenomenon. In contrast, the staphylococcus is the only organism ordinarily sensitive to penicillin which includes a significant number of resistant strains. A number of possible explanations entirely extrinsic to the organism exist which may explain this selective development of resistance, and it may be premature to hope that ultimately all pathogenic organisms will not become resistant to now available antibiotics.—L. R. Sante, M.D., St. Louis; The Journal of the Mo. State Med. Assn., Vol. 43, No. 8, August, 1946.

KEEPING UP WITH MEDICINE

THE main bad eating habits of our people are: Eating and drinking between meals; failure to eat green vegetables, fruit, and milk; relying too much on canned foods; faulty cooking of vegetables; self-proscribed reducing diets; and overeating. Proteins, iron, vitamin B-complex, calcium, vitamins D, C, and A, are all too often missing.

* * *

LOW sodium diets have been found beneficial in hypertension. Certain it is that all of us eat too much table salt. Herbivorous animals must have sodium to neutralize their accumulation of excess potassium, but you and I get our salt with our food and so we can throw away the salt shaker both from the table and the kitchen.

* * *

THE susceptibility of hypertrophied, or even normal-sized tonsils to infection is the result of pre-existing basic disturbances which, if not corrected after the tonsils have been removed, will continue to exert an unfavorable influence on the child's body. Most important of all is the regulation of the diet.

* * *

ACTINIC dermatoses in man can take the form of acute, subacute, or chronic dermatitis, urticaria, lupus erythematosus eruptions, hydroa vacciniforme, summer prurigo, and certain pigmentary disturbances.

* * *

THE psychosomatic approach to diagnosis is not new. It is the approach of the old-time family doctor. We are now growing out of the mechanical age and the new emphasis on the patient as a whole, his hates, loves, fears, and stresses, is a good sign sociologically as well as medically.

* * *

IT is now apparent that liver contains many substances that are of value to many. I wonder if the habit of eating a small piece of liver every morning for breakfast might not be a good idea.

* * *

BACTERIUM coli infection of the urinary tract is a well-known, although rare, cause of uticaria.

* * *

MOLES showing activity such as increased pigmentation, vascularity, bleeding, ulceration, and growth, should be radically excised.

* * *

AN educated person whose nervous system has grown along the lines which it has been trained, is less easily influenced by emotional considerations but even an intelligent, trained mind may succumb to his wishes, hopes, and fears.—J.F.

165 Acute Combined Wounds of the Thorax and Abdomen*

WILLIAM H. FALOR, M.D., HOWARD W. JONES, JR., M.D., and CHARLES B. BURBANK, M.D.

OF all war wounds probably none is more unique to war itself than is a combined wound of the thorax and abdomen; mutilating wounds of the extremities are frequently seen in civilian medicine as, too, are penetrating wounds of the thorax or abdomen; however, the combination of the latter two injuries with or without associated other injuries is a relative rarity outside of war surgery. Several General Surgery Teams of the 5th Auxiliary Surgical Group operated upon 165 combined wounds of the thorax and abdomen with 39 deaths, a mortality rate of 24 per cent; a general and statistical review of these cases constitutes a basis for this report. Included among these patients are American servicemen, allied and enemy personnel, and civilians. It is believed that less than an additional 2 per cent of cases expired before surgery could be attempted or because it was considered futile. The high mortality from shock in the initial 12-hour postoperative period bears testimony to the fact that poor risk patients were not finessed.

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CLASSIFICATION

Efforts by various authors[1,2] to separate combined injuries according to the course of the projectile have resulted in a classification of most cases into one of the following categories: (1) Thoracoabdominal wound, in which the missile travels from the thorax into the abdomen, (2) abdominothoracic wound, in which it travels from the abdomen into the thorax, and (3) separate wounds of the thorax and abdomen, in which there is a separate missile accountable for each of the wounds of the thorax and abdomen. Such classification is felt to be purely of academic value. In this series it was frequently impossible to tell in avulsing wounds and in through-and-through small arms wounds of the wall of the thorax and abdomen, the course of the agent. Regardless of the course or whether the wounds were made by one or two agents, the mortality rate was approximately the same. See Table I.

Of far greater prognostic value is a classification of cases according to **the side of the abdomen suffering the major injury.** Table II reveals that an injury of the left side carries with it an almost 50 per cent greater mortality rate than does an injury of the right side. Ordinarily the thorax was involved on the same side as the abdomen. However, rarely a projectile traveled from one side to the other; and more commonly, one agent injured one side and a second the opposite side.

TABLE I

Mortality Rate According to Types of Wounds

	Cases	Deaths	Mortality
Thoracoabdominal Wound	118	27	23%
Abdominothoracic Wound	19	4	21%
Separate Wounds of the Thorax and Abdomen	25	6	24%
Thoracoabdominal and Abdominal Injury in Same Patient	3	2	66%

In this paper, combined wounds of the thorax and abdomen will be classified as shown in Table III: (1) Thoracoabdominal wound—in which a projectile has traversed the diaphragm in passing from the thorax to the abdomen, or vice versa; and (2) separate wounds of the thorax and abdomen—in which two separate projectiles have been responsible for the wounds of the thorax and abdomen and in which there is no perforation of the diaphragm. These two main classes will then be subdivided into: (a) Injuries of the left side, and (b) injuries of the right side, according to the side of the abdomen suffering the major injury.

Twenty-four per cent of all wounds were complicated by the presence of other injuries ranging in severity from multiple penetrating shell fragment wounds to compound fracture of both femurs; with such additional injuries the mortality rate was 28 per cent compared to 22 per cent in the uncomplicated cases. The effect on the mortality rate as thoracic viscerae were also injured is shown in the 26 per cent increase in mortality in left-sided wounds—see Table IV. The negligible effect of such additional injury in right-sided wounds (Table IV) emphasizes the

*From patients treated by several General Surgery Teams of the 5th Auxiliary Surgical Group during the European Campaign. Submitted April 16, 1946.

TABLE II

Influence of Side of Injury on Mortality

INJURIES OF THE RIGHT SIDE Cases	Deaths	% Mort.		INJURIES OF THE LEFT SIDE Cases	Deaths	% Mort.
10	2	20%	Separate Wounds of the Thorax and Abdomen	15	4	27%
57	10	18%	Thoracoabdominal Wounds	83	23	28%
67	12	18%	Totals	98	27	28%

TABLE III

Combined Wounds of the Thorax and Abdomen

I. Thoracoabdominal Wounds.
   A. Right Sided
   B. Left Sided.

II. Separate Wounds of the Thorax and Abdomen.
   A. Right Sided
   B. Left Sided

TABLE IV

Influence on Mortality of Injury to Thoracic Viscera

INJURIES OF THE RIGHT SIDE Cases	Deaths	% Mort.		INJURIES OF THE LEFT SIDE Cases	Deaths	% Mort.
36	6	17%	All Patients without Damage to Thoracic Viscera	62	11	18%
31	6	19%	All Patients with Damage to Thoracic Viscera	36	16	44%

far wider margin of safety in patients so injured, and reemphasizes the rationale of classifying lesions of the two sides separately.

ANESTHESIA AND POSTOPERATIVE BRONCHOSCOPY

Intratracheal gas-oxygen-ether anesthesia employing a nasal or, more commonly, an oral tube was employed in 92 per cent of cases. The use of positive pressure in the presence of an open chest was routine; 2-3 mm. water pressure prevented mediastinal shift; 10-12 mm. for a brief period every 30 minutes and upon closing the thorax was found to be invaluable in effecting complete pulmonary re-expansion. Toward the termination of the campaign, bronchoscopy was routinely performed postoperatively by some teams in an effort to clear the bronchopulmonary tree of retained blood and mucus, particularly in the patient with lung injury. "Traumatic wet lung", described by Burford, et al.,[3, 4] was observed in all degrees of severity ranging from a few rales under a fractured rib to the consolidated hemorrhago-mucoid lung to be described later (Mortality, B. Excessive Parenteral Fluid Therapy). The degree of such 'wetness' was found to vary according to many factors, the more important of which were: (a) the severity of the direct thoracic wall and pulmonary trauma; (b) the type and volume of parenteral fluid therapy; (c) the length of time intervening between injury and complete tracheobronchial aspiration and pulmonary re-expansion; and (d) the relative effectiveness of efforts to produce painless, volumetrically normal respiration of particularly the injured lung.

Atelectasis of clinical importance occurred 3 times, all in non-bronchoscoped patients, and of these one died of pneumonia; the other two were successfully treated by bronchoscopy. A diagnosis of pneumonia was made in 7 patients; of these 5 died; bronchoscopy had been performed in one non-fatal and in one fatal case.

The dorsal decubitus position was used wherever possible to minimize restriction of excursion of the unaffected lung as well as to minimize drainage into it.

INCISION AND CLOSURE

A. Separate Wounds of the Thorax and Abdomen.

In the absence of respiratory embarrassment or of signs of a cardiac or major vascular lesion or of a severe lung laceration celiotomy was usually performed first. Occasionally a minor debridement was the only indicated therapy for the thoracic wound. Types of incision and closure are considered in detail under "Thoracoabdominal Wounds".

B. Thoracoabdominal Wounds.

Table V reveals that operative procedures were performed through one major incision in 96 of 140 thoracoabdominal wounds, and that 41 per cent of these procedures were done through a thoracotomy. Thoracotomy was perfomed first in 75 per cent of 44 cases operated by two major incisions. Thus, thoracotomy was performed

TABLE V

Order of Incisions in Thoracoabdominal Cases

A. Cases Performed by One Major Incision

Incision	Left Side	Right Side	Totals
Thoracotomy Only	22 Cases	17 Cases	39 Cases
Laparotomy Only	36 Cases	21 Cases	57 Cases

B. Cases Performed by Combined Thoracotomy and Laparotomy Incisions

Initial Incision	Left Side	Right Side	Totals
Thoracotomy	19 Cases	14 Cases	33 Cases
Laparotomy	6 Cases	5 Cases	11 Cases

first or exclusively in 52 per cent of the thoracoabdominal cases.

The choice of the locus for the initial incision depended upon: (1) The extent and nature of the intrathoracic and intra-abdominal injury; and (2) the location of the wound, its extent, and its course.

Thoracotomy more commonly was the initial or the only incision because of 3 factors: (1) The wound of entrance was located in the thorax in 84 per cent of recorded cases. (2) The etiologic factor in 68 per cent of cases was a shell fragment. Characteristically a shell fragment because of its tumbling, rotating motion created a gaping, sucking wound of the thorax and diaphragm in contradistinction to the often sealed-over wounds caused by small arms fire. (3) A missile rarely traveled more than 45 degrees away from a horizontal course, thus all injured thoracic viscera and usually all injured abdominal viscera were available through a thoracotomy and transdiaphragmatic celiotomy.

However, in small arms wounds the latter procedure was considered unwise, unless there was evidence of a cardiac or vascular lesion, or of a severely lacerated lung, or of a diaphragmatic hernia. The customary small perforation of the diaphragm must be widely enlarged for such a procedure and a celiotomy may still be necessary for a proper treatment of the intra-abdominal lesions. Too, a celiotomy with a minimum of therapy to the thoracic wound is a far less shocking and time-consuming procedure than is a thoracotomy and transdiaphragmatic celiotomy.

In conclusion, in thoracoabdominal wounds the minimum indications for performing all surgery via the transthoracic route should be: A penetrating wound of the thoracic wall caused by a projectile whose course is in an almost transverse plane. This rule pertains only to thoracoabdominal wounds on the left side. The same indications hold for a right-sided thoracoabdominal wound where it can be told with certainty that the projectile has not proceeded in the region of the duodenum, right colon, or pancreas. These organs are unavailable by a transdiaphragmatic route because of the right lobe and main body of the liver. The repair of wounds of the diaphragm located over the extraperitoneal surface of the liver requires a thoracotomy for adequate exposure; thus a right-sided thoracoabdominal wound with major intra-abdominal injury can never be repaired by thoracotomy alone. Here in operative approach is found added rationale for a separate consideration of wounds of the right and left side.

1. Thoracic and Diaphragmatic Incisions and Closure.

Initially a limited debridement of skin and soft tissue was performed saving as much apparently viable tissue as possible for the closure. In avulsing wounds closure was frequently difficult because of a lack of available tissue. Commonly in such wounds, the rough bone edges were rongeured and more rib resected or an intercostal extension was added to provide an adequate chest opening. After a careful chest toilet and repair of visceral injury the laceration in the diaphragm was treated according to the demands of the individual case; a radial extension was the method of extending a laceration for transdiaphragmatic procedures. In cases with a small wound of chest entrance, especially with suspected heart or extensive lung injury, a formal intercostal thoracotomy was employed more commonly than the longer procedure of rib resection. A hockey-stick shaped incision extending up from the rectus and then laterally in an intercostal space to open both abdomen and thorax was found useful in low-lying anterior thoracic lesions. This incision proved difficult to close because of the paucity of tissues at the costodiaphragmatic junction; a suture of the diaphragm to the initial portion of the thoracic extension of the incision greatly facilitated closure.

Avulsing wounds posteriorly were readily closed by the use of the back muscles. However, anterior and anterolateral avulsed areas could only be closed by the mobilization of a muscle flap: the pectoralis major muscle for wounds above the 5th interspace, the latissimus dorsi for wounds below that level.

The diaphragm was used to close low-lying avulsed wounds, and the addition of an osteotomy at either end of the rib forming the superior border of the wound mobilized that edge enough to make its suture to the diaphragm tension-free. Marsupialization of a severely macerated right side of the liver was performed through a

low-lying large avulsed wound of the thoracic wall in 4 cases without mortality. The edges of the lacerated diaphragm were sutured to the edge of the chest wall wound to close the pleural cavity, and the exteriorized liver was then packed with gauze.

A phrenic crush commonly preceded such a maneuver both to facilitate the operative procedure as well as to immobilize the diaphragm postoperatively and minimize the possibility of a wound breakdown and possible sucking chest wound. A phrenic crush was infrequently employed in other wounds of the diaphragm, for it was felt preferable to maintain maximum expansion of the injured, sutured lung in an attempt to prevent chest complications rather than to immobilize the sutured diaphragm and help prevent the much less serious complication of diaphragm-wound separation. Injection of the phrenic nerve with procaine was used occasionally in a difficult closure. Routine closure of the diaphragm at the end of the campaign was by interrupted heavy black silk sutures.

2. Abdominal Incisions and Closure.

Wherever possible abdominal wounds were not incorporated in the incision but were debrided separately and dressed with vaseline gauze. The type of abdominal incision was governed principally by the course of the projectile, and to a lesser extent by the degree of the costal margin angle at the ziphoid. In a patient with a wide costal flare a subcostal incision was found to provide excellent exposure for repairing the diaphragm and stomach and for both an exploration and removal, if necessary, of the spleen and kidney; however, in the asthenic individual a rectus incision was found to provide a good exposure and had the additional value over the subcostal incision of allowing for a more easy stab-wound exteriorization of injured colon.

Closure commonly was in layers using catgut suture material; rarely was silk or cotton used throughout. A few surgeons routinely closed incisions with through-and-through sutures of steel wire, of about 0.028 diameter. It was generally felt that the latter closure should be reserved for the difficult to close case and for the patient in extremis for whom rapid closure was considered to be life-saving. Retention sutures, commonly of heavy black silk, were routinely used.

WOUNDS OF SPECIFIC ORGANS

A. Wounds of the Thoracic Viscera.

1. Heart and Great Thoracic Vessels.

Two cases presented heart lesions; they were: (1) A laceration of the right auricle, severe. The patient expired of acute hemorrhage from the heart wound before the thorax could be opened. (2) A lacerated tip of the left ventricle and a 2 cm. laceration of the posterior wall of the right ventricle with an associated cardiac tamponnade, and a laceration of the inferior vena cava. Operation consisted of suture of both ventricles. The vena caval injury below the diaphragm was overlooked and only discovered at autopsy on the 5th postoperative day after the patient apparently strained and dislodged the clot.

There were four lacerations and one contusion of the pericardium with five deaths, none attributable to the pericardium injury. One patient with a laceration of the inferior vena cava at its diaphragmatic hiatus expired two hours postoperative after the irretrievable foreign body had dislodged and traveled up the inferior vena cava through the heart and lodged in the right pulmonary artery as a pulmonary embolus.

Only one instance of an actively bleeding intercostal artery was found at surgery and that was in a patient whose blood pressure had been elevated by strenuous intravenous therapy to 160/90. One bleeding internal mammary vessel required ligation.

2. Lung.

There were 63 known lacerations of the lung of which 20 were sutured. No active bleeding was encountered, and sutures were placed to treat or to prevent a bronchopleural fistula. An attempt was made to remove all foreign bodies, of metal, clothing, dirt, bone, etc., from the lung parenchyma.

Chest drainage was effected by both needle-aspiration and catheter. An effective method of employing a catheter was to use a fairly firm No. 30 F rubber catheter or rectal tube with numerous holes cut on both sides of the tube for its terminal eight inches; this was inserted intercostally at the posterolateral aspect of the costo-diaphragmatic angle and threaded under direct vision until it described a gentle curve along the lateral thoracic wall. The tip of the tube was fixed by one catgut suture to the parietal pleura in the region of the 3rd interspace in the anterior axillary line. Both fluid and air drained into a water-seal for the 48 hours the tube was left in situs; the addition of Wangensteen suction to the water-seal was found to effect more complete emptying of the thorax. Re-expansion of the lung was frequently effected at the end of the operation by the application of positive pressure through the intratracheal tube together with negative pressure on the catheter; thus, both lungs were slowly and completely expanded.

B. Wounds of the Abdominal Viscera.

1. Liver and Gall Bladder (Table VI).

Liver wounds were infrequently found to be bleeding in spite of the fact that several partial amputations of a section of a lobe were seen. However, the removal of foreign bodies or of devitalized parenchyma or the injudicious handling of the liver not infrequently restarted bleed-

TABLE VI

A. Mortality Rate in Specific Organ Injuries

Organ	Left Side			Right Side			Totals		
	Cases	Deaths	% Mort.	Cases	Deaths	% Mort.	Cases	Deaths	% Mort.
Liver	22	7	32%	53	10	19%	75	17	23%
Spleen	42	10	24%	---	---	------	42	10	24%
Kidney	13	5	38%	9	2	22%	22	7	32%
Stomach	39	16	41%	1	0	0%	40	16	40%
Small Intestine	19	10	53%	6	2	33%	25	12	48%
Large Intestine	30	13	43%	12	3	25%	42	16	38%
B. Mortality Rate in Combinations of Specific Organ Injury									
Stomach and Small Intestine	2	1	50%	---	---	------	---	---	------
Small and Large Intestine	5	2	40%	3	2	66%	8	4	50%
Stomach and Large Intestine	2	1	50%	---	---	------	---	---	------
Stomach and Small and Large Intestine	7	6	86%	---	---	------	---	---	------
Spleen and Stomach	12	3	25%	---	---	------	---	---	------
Spleen and Large Intestine	3	0	0%	---	---	------	---	---	------
Spleen and Stomach and Large Intestine	3	2	66%	---	---	------	---	---	------
Spleen, Stomach, Sm. and Lg. Int.	3	1	33%	---	---	------	---	---	------

TABLE VII

Treatment of Injuries of the Spleen

Therapy	Cases	Deaths	% Mortality
None	5	0	0%
Suture	1	0	0%
Abdominal Splenectomy	24	7	29%
Transdiaphragmatic Splenectomy	12	3	25%
Totals	42	10	24%

ing which was only controlled by packing with gauze, or by suture with a graft of omentum or muscle, or by the previously described marsupialization of the injury together with packing. Though the liver usually will tamponnade small right-sided centrally located lacerations of the diaphragm, these lacerations were routinely closed to prevent hepatopleural fistulae.

Drainage of the liver commonly was continued for at least 8 to 10 days in an effort to minimize the incidence of bile peritonitis. Sequellae in several lacerations effecting approximately 25 per cent of the liver bulk were limited to profuse bile drainage for a week or more together with a paralytic ileus prolonged beyond that consistent with the extent of the allied injuries; such ileus was a common sequella in patients with liver injuries.

Two lacerations of the gallbladder were treated, one by cholecystectomy and the other by cholecystotomy; the latter expired on the 6th postoperative day of pneumonia.

2. Spleen (Table VI).

The spleen was the most commonly injured left-sided abdominal organ, and the over-all mortality of 28 per cent for splenectomy stands out in sharp contrast to the almost 100 per cent mortality of World War I quoted in the Military Surgical Manual.[5] There was no recognized case of splenic vein thrombosis in this series.

Table VII reveals that 6 injured spleens were not removed; these had minor injuries, i. e., small, non-bleeding laceration or confusion. It was thought that their removal would increase operating time and shock sufficiently to outweigh the remote chance of subsequent bleeding or of a delayed rupture of the spleen. Sixty-six per cent of the splenectomies were performed through an abdominal incision; Table VII reveals little difference in mortality between the two operative routes, though the procedure was far easier through the thoracic approach.

3. Large Intestine (Table VI).

Lesions of the large intestine occurred in 25 per cent of the 165 patients; they were treated abdominally by a loop exteriorization of the injured portion, preferably through a stab wound to minimize the possibility of sepsis in the formal incision. Initially in the campaign the Mikulicz Procedure was routine. It was later abandoned because it was found that loop colostomies could be resected in the General Hospitals and an end-to-end anastomosis of the large bowel performed and the repaired loop safely dropped back into the peritoneal cavity. Though frank contamination of the peritoneal cavity with liquid feces or by mixture of blood and feces carried a high mortality from shock during the first 48 hours postoperative, the same contaminants in the thorax were attended by a mortality rate of almost 100 per cent.

4. Stomach (Table VI).

Lesions of the stomach occurred in 24 per cent of all cases. Herniation into the thorax occurred in 5 recorded cases with 1 mortality. In 2 of these cases there was no stomach perforation. The high mortality in stomach lacerations is explained by the almost invariable presence of associated other abdominal visceral lesions—an incidence of 73 per cent even when the combinations of stomach and liver injury, and of stomach and kidney injury are excluded. The shock and chemical peritonitis attendant on stomach perfor-

TABLE VIII

Lesions of the Small Intestine

Procedure	Cases	Deaths	% Mortality
Single Suture	6	3	50%
Multiple Sutures	14	6	43%
One Anastamosis	2	2	100%
One Anastamosis plus Multiple Sutures	3	1	33%
Totals	25	12	48%

TABLE IX

Incidence of Visceral Injury

Abdominal Injury	Right Side			Left Side			Totals		
	CASES	DTHS	% MORT	CASES	DTHS	% MORT	CASES	DTHS	% MORT
Limited to Retroperitoneal Hematoma or laceration of Omentum or Mesentery	4	0	0%	4	0	0%	8	0	0%
One Abdominal Viscus Injured	42	6	14%	38	8	21%	80	14	18%
Multiple Abdominal Viscera Injured	21	6	29%	56	19	34%	77	25	32%

ation with spillage of gastric contents also contributed materially to raise the mortality rate.

5. Small Intestine (Table VI).

Lesions of the small intestine occurred in 15 per cent of all cases and were treated as shown in Table VIII. The high mortality again is explained by the multiplicity of injuries in cases having small bowel lacerations as well as by the toxicity of spilled small bowel contents, particularly when mixed with blood. The segregation of cases according to the therapy in Table VIII is only for purposes of describing the therapy.

6. Kidney (Table VI).

Lesions of the kidney occurred in 12 per cent of all patients with a mortality of 32 per cent; 86 per cent of these mortalities occurred in patients suffering another injury to an abdominal viscus or some other major injury to the body. Four kindeys were sutured with 2 deaths; 4 nephrectomies, 2 transdiaphragmatic, and 2 transabdominal, were performed with 1 death. Four deaths occurred in 12 patients with minor kidney lacerations or contusions; the therapy in this group was at most drainage of the perirenal space. Nephrectomy and even suture was reserved for the most macerated organs in an effort to minimize total operating time as well as shock-producing surgery. Extraperitoneal drainage through a stab wound was commonly instituted, but rarely was there either urinary or sanguinous drainage so that the value of this procedure was questionable.

Transperitoneal nephrectomy was considered

TABLE X

Mortality Rate In Large Hemoperitoneum and Hemothorax

Aspirated Blood Volume	Cases	Deaths	% Mort.
0-500 cc.	3	0	0%
500-1000 cc.	13	3	23%
1000-1500 cc.	3	1	33%
1500-2000 cc.	3	2	66%
2000-3000 cc.	3	2	66%
Total	25	8	32%

the procedure of choice not only because the prerenal peritoneum was commonly lacerated but, too, because the procedure was readily performed with a minimum of shock through the single celiotomy incision.

7. Combination of Abdominal Lesions.

More than one abdominal viscus was injured in 47 per cent of all combined wounds of the thorax and abdomen. Table IX reveals the marked mortality increase as more than one viscus is injured. The high mortality rate to be expected in cases presenting a combination of wounds of the stomach, spleen, small intestine, and large intestine is shown in Table VI.

C. Miscellaneous Considerations.

1. Evisceration.

Evisceration of abdominal contents into the thorax occurred commonly in the 140 thoracoabdominal cases; strangulating evisceration occurred in 13 cases with a mortality of 40 per cent. Incarceration not infrequently was due to the hooking or bayonetting of the herniated viscus onto a sharp point of a fractured rib, and such herniae commonly could only be reduced by a thoracotomy. X-ray evidence of evisceration was usually substantiated clinically by severe dyspnea, and an initial thoracotomy commonly was performed to repair lesions of the eviscerated organs, reduce them into the abdomen, and repair the diaphragm.

2. Hemoperitoneum and Hemothorax.

Table X reveals the aspirated volume of hemoperitoneum and hemothorax found in 25 recorded cases. Thoracic injuries contributed but a small portion of the total blood volume; injuries of the spleen and, to a lesser degree, of the stomach and small intestine accounted for the major portion of the blood. Shock from blood loss and from associated visceral injury may be adequate explanation for the mortality rate shown in Table X; however, postoperative morbidity, particularly ileus, was increased as the volume of such intraperitoneal blood increased, and it seems reasonable that mortality may be similarly increased, i. e., by some factor other than shock.

3. Retroperitoneal Hematoma.

Retroperitoneal hematomata commonly occurred with kidney lesions and were considered of

minor importance, though prolonged ileus usually was associated with them.

MORBIDITY

A. Thoracic.

1. Wound Sepsis.

Wound sepsis of the traumatic wound, of the elective incision, or of stab and drainage wounds was rare.

2. Intrapleural Fluid.

Needle thoracentesis was more commonly employed than catheter drainage being used 1.4 times per patient with an average yield of 310 cc. of serosanguineous fluid and a lesser volume of air. The initial tap was usually done 24 to 48 hours postoperative; not infrequently additional taps were necessary and particularly after the routine X-ray taken on the 6th or 7th day postoperative had revealed available pleural fluid.

3. Broncho-Pleural Fistula.

Two recognized broncho-pleural fistulae developed in the first 24 hours and spontaneously closed after institution of catheter drainage of the chest through the second interspace. There is little doubt, however, that more fistulae developed and either were unrecognized or were not recorded.

4. Traumatic Wet Lung.

The symptom complex of tramatic wet lung[3,4] has briefly been discussed (Anesthesia and Postoperative Bronchoscopy). Dangerous sequellae from such bronchopulmonary obstruction was minimized by the routine postoperative catheter aspiration of the tracheo-bronchial tree and by the common practice of bronchoscopy where the degree of intrathoracic injury was more severe. Intercostal nerves commonly were severed by the injury or purposely by the surgeon to produce painless postoperative respiration. Intercostal nerve block with procaine was used as an accessory in attaining painless respiration.

5. Atelectasis.

The incidence of atelectasis is unknown because of inadequate records, however at least two cases required bronchoscopy and were successfully treated.

6. Pneumonia.

Non-fatal lobar pneumonia was diagnosed in two patients; one developed an early empyema or infected hemothorax, the only incidence in this series of either of these sequella, prior to evacuation.

7. Hepato-Pleural Fistula.

There was no diagnosed case of hepato-pleural fistula with bile pleuritis in the 75 cases of liver injury.

B. Abdominal.

1. Wound Sepsis.

Wound sepsis either of the original traumatic wound, the stab wounds, or of the elective incision was rare.

2. Wound disruption.

Three wound disruptions were recorded with one death; one evisceration of omentum occurred. For either retention sutures or through-and-through sutures wire of a diameter less than 0.018 was apt to break under moderate wound tension; thus, 0.028 gauge wire commonly was used.

3. Perirenal Drainage.

Drainage from kidney injuries was negligible both for blood and urine, and it appears that the stab wound is a needless procedure except in lesions that effect a major calyx or the renal pelvis.

4. Liver Drainage.

Wounds of the liver drained in proportion to the severity of the laceration; drainage volumes up to 1500 cc. the first day were not uncommon, and some drainages persisted in a fair volume even at time of evacuation.

5. Paralytic Ileus.

Paralytic ileus was usually prolonged to four to six days postoperative in cases with retroperitoneal hematoma, or extensive liver injury, or a large hemoperitoneum.

MORTALITY

Table XI presents a breakdown of the thirty-nine deaths according to the cause of death, the time interval between operation and death, and the performance of autopsies. Forty-nine per cent of all deaths occurred in the first 24 hours; 77 per cent occurred in the first 72 hours. Autopsies were performed on 54 per cent of the patients.

A. Shock.

Shock accounted for 51 per cent of the fatalities, and of this group 75 per cent expired in the first 24 hours. The etiology of shock was almost always a combination of many factors, e.g., hemorrhage, trauma, exposure, delayed and, or, prolonged evacuation over difficult terrain, etc. An analysis of preoperative parenteral therapy administered to 47 patients reveals a minimum therapy of one unit of plasma and a maximum of 6 units of blood and 9 units of plasma. Of these 47 cases, 6 received an average of 3.5 units of blood and 3.8 units of plasma; thus, 12 per cent of the patients received 22 per cent of all the blood and 30 per cent of all the plasma administered to the group of 47 patients. These 6 patients were finally deemed operable and all died of shock in the first 24-hour postoperative period. It was apparent that the prognosis was less favorable as larger amounts of blood and plasma were required.

Case No. 17 in Table XI is the only fatality presenting a single factor as the cause of shock and of death: on the fifth postoperative day, the

TABLE XI

Analysis of Mortalities

Injuries of the Left Side				Injuries of the Right Side		
Case No.	Time Interval: Operation to death	Autopsy Performed	Cause of Death	Case No.	Time Interval: Operation to death	Autopsy Performed
1.	Expired at operation	No	Shock	18.	Expired at Operation	Yes
2.	30 Minutes	Yes		19.	45 Minutes	No
3.	1 Hour	Yes		20.	24 Hours	No
4.	2 Hours	No				
5.	4 Hours	No				
6.	4 Hours	No				
7.	8 Hours	Yes				
8.	18 Hours	Yes				
9.	24 Hours	Yes				
10.	24 Hours	Yes				
11.	24 Hours	No				
12.	24 Hours	No				
13.	36 Hours	No				
14.	36 Hours	No				
15.	48 Hours	No				
16.	4 Days	No				
17.	5 Days	Yes				
21.	4 Hours	No	Pulmonary	25.	24 Hours	Yes
22.	3 Days	Yes	Edema	26.	24 Hours	Yes
23.	4 Days	Yes	and	27.	48 Hours	No
24.	4 Days	No	Hemorrhage	28.	3 Days	Yes
29.	3 Days	No	Pneumonia	33.	6 Days	Yes
30.	5 Days	Yes				
31.	5 Days	Yes				
32.	8 Days	Yes				
34.	2 Days	Yes	Peritonitis			
35.	8 Days	Yes				
			Misc. Causes	36.	2 Hours	Yes
				37.	5 Hours	No
				38.	2 Days	Yes
				39.	3 Days	No

clot in a missed perforation of the inferior vena cava dislodged and the patient died of hemorrhagic shock. Three patients either were never out of shock or lapsed back into shock to die in the second 24-hour postoperative period. One patient suffered evisceration of a perforated stomach, small intestine, and transverse colon through a 7 x 6 cm. avulsed wound of the left lower lateral thorax. He was operated and during his 96-hour postoperative period was irrational and uncontrollable, and had a systolic blood pressure ranging from 80-90 mm. Hg. Not infrequently patients so severely wounded presented a similar syndrome of 'chronic shock' characterized by moderate apprehension to severe restlessness, a variable degree of disorientation, a systolic blood pressure of from 70-90 mm. Hg., and a pulse of 100-140 per minute. Occasionally a renal shutdown was a part of the syndrome, and when of such duration rarely was relieved by therapy.

The decision as to the parenteral postoperative fluid therapy of such patients required extreme caution that enough fluid-blood, plasma, saline, and distilled water was administered to re-establish and sustain normal body fluids but that too much was not given thus precipitating pulmonary edema, with or without hemorrhage into the lungs, and probable death. The margin of safety between these two extremes—shock and an overloaded cardiovascular system—became progressively less as the total injury was more severe. However, because of the ready availability of all parenteral fluids and particularly blood, and because of the desire to relieve rapidly such 'chronic shock' by giving what was considered an adequate fluid volume more errors were made toward overloading the cardiovascular system. It was finally felt that the patient who had a stabilized blood pressure of approximately 80 mm. Hg. systolic with a pulse of 100-140 per minute and who showed no signs of increasing physical exhaustion should be given his daily 3500 cc. of saline and distilled water very slowly, preferably by hypodermoclysis. If blood was to be given, it should replace the former fluid, volume for volume, and should be given very slowly.

B. Excessive Parenteral Fluid Therapy.

Eight patients expired of acute pulmonary edema; 5 of these had profuse terminal serohemorrhagic fluid in the bronchial tree. In 4 autopsied cases this fluid proved to arise from

lungs that were grossly enlarged, heavy, firm, and engorged with blood and edema. Microscopic sections revealed edema, gross acute passive congestion, alveoli containing red blood cells, and areas suggestive of the consolidation of bronchopneumonia. The surgeons of patients No. 22, No. 26, and No. 28 felt conclusively that they had overloaded the cardiovascular system of these patients; patient No. 26 received preoperatively 1 unit of blood and 3 of plasma and at operation 11 units of plasma and 4 of blood; patient No. 28 received 1500 cc. of saline and 2000 cc. of blood—prepared in Alsever's Solution—within a period of approximately 2½ hours. Patients No. 22, No. 23, No. 24, No. 26, No. 27, and No. 28 presented the syndrome of 'chronic shock"; of these 6 patients, 3 expired because of an acknowledged excessive administration of parenteral fluids.

C. Pneumonia.

Five patients expired of pneumonia, an incidence of 3 per cent in the 165 patients and of 13 per cent of all causes of death: credit for such a low mortality must be largely given to the use of chemotherapeutics and bronchial aspiration. Patient No. 29 is classified here and is also included in computing the total incidence of peritonitis, though it is unlikley that a fatal pneumonia developed in 3 days.

D. Peritonitis.

Three patients expired from peritonitis; case No. 29 was previously discussed (Pneumonia). Case No. 35 eviscerated on the 5th postoperative day. This low incidence of fatal peritonitis—2 per cent in 157 cases of abdominal organ injury—must be attributed to the combination of chemotherapeutics with adequate surgery.

E. Miscellaneous Causes.

Case No. 36 expired of pulmonary edema presumably associated with blast injury of the lung. This solitary example of blast injury may not accurately represent the incidence of this lesion as a contributory factor leading to death; however, autopsy and microscopic evidence failed to substantiate the belief that blast injury was a not uncommon cause of, or at least contributory factor to, death. Case No. 36 suffered multiple wounds covering his thighs, body, and head, and it was thus assumed that he was very close to the shell explosion and so the recipient of its full blast. His left membrana tympani was acutely ruptured. He never regained consciousness and was presumed to have a blast injury to the brain as well as to his lungs.

Case No. 37 suffered an extensive laceration of his liver as the only indicted cause of death; he may have had a bile peritonitis.

Case No. 38 expired as a result of a shell fragment dislodging from his inferior vena cava and traveling to his right pulmonary artery where it acted as a pulmonary embolus.

Case No. 39 succumbed to a rapidly spreading retroperitoneal infection from a missed perforation of the cecum.

The total part played by Fat Embolus in the cause of these deaths is unknown, however, no known microscopic specimen submitted from approximately 50 per cent of the autopsies was positive for fat.

CONCLUSION

One hundred and sixty-five combined wounds of the thorax and abdomen operated by several General Surgical Teams of the 5th Auxiliary Surgical Group during the period September, 1944, to May, 1945, have been analyzed. Included are so-called thoracoabdominal wounds, abdominothoracic wounds, and separate wounds of the thorax and abdomen. The rationale for altering such a classification and for further classifying such wounds into wounds of the right side and wounds of the left side, according to the side of the abdomen that sustains the major injury, is presented. Incisions are discussed together with the indications for performing all procedures through one incision.

Mortality rates associated with wounds of specific viscera are considered as, too, is the rise in mortality that is associated with an increase in the number of viscera injured. Shock in the first 24-hour postoperative period is shown to be the principal cause of death; sepsis in its various forms is but a minor cause. The syndromes of 'traumatic wet lung' and 'chronic shock' are discussed. A plea is made for the performance of a minimum of initial surgery to be done as rapidly and atraumatically as possible and to be followed by a most careful administration of parenteral fluid—an adequate volume to prevent or treat shock and not enough to precipitate pulmonary edema and hemorrhage and death.

BIBLIOGRAPHY

1. Blackburn, Guy, and d'Abreu, A. L.: Thoraco-Abdominal Wounds in War, Brit. J. Surg. xxxiii:152, 1945.
2. Welch, Charles Stuart, and Tuhy, John E.: Combined Injuries of the Thorax and Abdomen, Ann. Surg. 122:358, 1945.
3. Burford, Thomas H., and Burbank, Benjamin: Traumatic Wet Lung, J. Thoracic Surg. 14:415, 1945.
4. Brewer, Lyman A., Burbank, Benjamin, Sampson, Paul C., and Schiff, Charles A.: The "Wet Lung" in War Casualties, Ann. Surg. 123:343, 1946.
5. Military Surgical Manual, Volume III. Abdominal and Genito-Urinary Injuries. W. B. Saunders Co., Philadelphia, 1942.

Case-finding in a hospital finds tuberculosis—the first essential in any tuberculosis program. It provides the hospital with a knowledge of all of the tuberculosis within its walls. It improves the hospital competency and removes a hazard to patients and personnel—the unrecognized case. It is bound to improve community health.—W. H. Oatway, Jr., M.D., NTA Bull. Nov., 1945.

Demonstration of Tubercle Bacilli—Survey of Methods Used in Ohio and Recommended Procedures

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IT IS now imperative that more sensitive methods for the demonstration of tubercle bacilli be generally employed. Casual examination of unconcentrated exudates for tubercle bacilli will not suffice for the differential evaluation of lesions as disclosed by routine or survey chest X-rays. Improved methods of treatment for the tuberculous patient and possibly chemotherapy in the future, also, indicate the need for correspondingly improved bacteriologic evaluations. Sensitive methods for demonstrating tubercle bacilli, in addition, provide greater assurance to the discharged patient, his family, and the community that relapse and spread of tuberculous infection are less likely to occur. Finally, on the basis of numerous cases of cancer, silicosis, bronchiectasis, fungus diseases and others misdiagnosed as tuberculosis, it is apparent to physicians in tuberculosis hospitals that there is an embarrassing neglect in checking X-ray diagnoses by bacteriologic methods. Or, as a result of inadequate laboratory facilities, the disease process when diagnosed is hopelessly far advanced.

Evaluations of the relative importance of the various methods for demonstrating tubercle bacilli have recently been made by Sweany[1] of the Chicago Municipal Tuberculosis Hospital and Pinner[2] of the Division of Pulmonary Diseases of the Montefiore Hospital. Sweany's comparative study of methods for demonstrating tubercle bacilli in sputum revealed the following:

	Per Cent
Positive on direct smear	72
Negative on direct smear but positive on concentration	13.09
Negative on concentration but positive on culture and animal inoculation	5.26
Negative by every method but positive on stomach lavage	2.70
Non-tuberculous	2.79
Entirely negative	4.16
	100.00

Pinner's study revealed results at variance with Sweany's and emphasizes the value of the more sensitive methods.

From the Percy Shield's Laboratory of Dunham Hospital, John H. Skavlem Medical Director. (A Sub-Department of the Department of Medicine, University of Cincinnati.) Submitted March 27,1946.

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	Per Cent
Direct sputum smear	33.7
Sputum concentrate	27.0
Sputum culture	16.2
Gastric concentrate	5.3
Gastric culture	17.8
	100.0

From these studies it is clearly evident that concentration, gastric lavage, culture and animal inoculation are profitable additions for the demonstration of tubercle bacilli, and that sputum negative by concentration may still be positive by other methods. Frequently, the question is raised in regard to doubtful cases as to the number of specimens that should be examined before tuberculosis is excluded. Pinner's study[2] further showed that, regardless of the method used, the first positive would occur on specimen number:

1	2	3	4	5	6	7 or more
44.6%	12.3%	14.7%	3.9%	3.9%	2.3%	4.4%
71.6%						

negative throughout 13.7%.

Thus, 83 per cent of all positive patients would be disclosed by the examination of three specimens, and six examinations would reveal 95 per cent of all positives. A study, similar

to Pinner's conducted on concentrated sputum specimens at Dunham Hospital revealed that the first positive would occur on specimen number:

1	2	3	4	5	6	7	or more
62.3%	4.5%	1.9%	.9%	.5%	.9%	.9%	
68.7%							

negative throughout 28.1%.

With concentration, 95 per cent of all positives were disclosed by the examination of three specimens.

In view of the ambitious tuberculosis program being launched in Ohio, it would be important, then, to know the efficiency of the various types of clinical laboratories throughout the state in providing critical bacteriologic work in demonstrating acidfast bacilli. To gain some answer to this problem, questionnaires as to methods used in demonstrating acid-fast bacilli were sent to 12 public health, 13 tuberculosis, and 34 general hospital laboratories. Responses were obtained from 9 public health laboratories, 11 tuberculosis, and 13 general hospital laboratories. The tabulated results reveal wide variations as to methods and criteria for negativity, and insufficient use of concentration and biologic techniques (Tables I, II, and III).

Although the superiority of concentration methods has long been known, public health laboratories, with the exception of one, routinely do direct smears. Since specimens sent to these laboratories are either for diagnostic purposes or for follow-up studies on discharged tuberculous patients, it would be desirable that all public health laboratories routinely employ concentration methods for sputum examinations and that biologic methods of demonstration be made available. The surveyed general hospitals offer the gamut of diagnostic facilities, although some have not realized the value of the more sensitive methods.

On the basis of previous chest X-ray surveys[3] it can be estimated that approximately 600-1,200 cases of active or inactive pulmonary tuberculosis are admitted yearly in the participating general hospitals which together admit approximately 70,000 patients a year.[4] It is also known that approximately 60 to 70 per cent of the active cases of pulmonary tuberculosis disclosed by X-ray surveys are of the minimal type.[3] For differential diagnostic purposes, then, and proper evaluation of activity of tuberculous lesions, it is obvious that concentration methods should not be used "only on request", but routinely, for many physicians are not acquainted with the relative merit of these methods. That tuberculosis hospitals do not uniformly employ con-

TABLE I

Type of Laboratory	No. Reporting	SPUTUM			GASTRIC			PLEURAL FLUID			Method of Concentration
		No. of Yearly Exams.	Routine Method		No. of Yearly Exams.	Routine Method		No of Yearly Exams.	Routine Method		
			Direct Smear	Concentration		Cent. Sed.	Concentration		Cent. Sed.	Concentration	
Public Health	9	20,000	8	1	0			0			NaOH 2X Chlorox 1X Antiformin 1X
			Concentration available "on request only" 3 Labs.								
General Hospital	13	4,180	8	5	250	7	6	320	10	3	NaOH 7X Caroid 2X Trypsin 1X Antiformin 2X Oxalic acid 1X
			Concentration available "on request only" 8 Labs.								
Tuberculosis Hospital	11	33,000	6	5	900	2	9	1,000	7	4	NaOH 9X Chlorox 1X
			Concentration available "on request only" 5 Labs.								

Table II

Type of Laboratory	No. of Reporting Labs.	BIOLOGIC DEMONSTRATION				
		Guinea Pig		Culture		Not Done
		No. Yearly Exams.	Done	No. Yearly Exams.	Done	
Public Health	9	0	2 labs.	0	2 labs.	7 labs.
General Hospital	13	295	8 labs.	625	8 labs.	1 lab.
Tuberculosis Hospital	11	536	5 labs.	950	9 labs.	2 labs.

centration methods for routine examinations is a surprise. One would expect that tuberculosis hospital laboratories would regularly use sensitive methods for diagnostic purposes, for evaluation of various pulmonary collapse procedures, and for determining when the patient is ready for discharge.

The surveyed tuberculosis hospitals have a combined yearly admission of approximately 2,500 patients,[4] and their discharge rate is two-thirds or three-fourths this number. On this basis, one would expect far more gastric lavage examinations with cultures or guinea pig inoculations than tabulated, if the patients were properly studied prior to discharge. Only one of the reporting tuberculosis hospitals regularly employs gastric lavage studies on patients to be discharged. In view of the high re-admission rates to tuberculosis hospitals it would be profitable to know the re-admission rate of those with positive and of those with negative gastric cultures on discharge. If it is not economically possible to keep "negative sputum" patients who have positive gastric cultures for further treatment, at least such patients could be more closely observed in out-patient dispensaries.

In all three types of laboratories there was no uniformity in method of examination: Some use time, and others, a field basis for determining negativity of smears. Time varied from 3 to 60 minutes per slide! Field basis varied from 25 fields per slide to examination of the entire (?) smear! It is true that either basis, if properly standardized, may be used; however, since the area covered microscopically will vary with technicians in a stated period of time, it would seem advisable that a definite number of fields be examined before the slide is considered as negative.

To meet, then, an apparent need, this article presents in brief outline the methods employed in this laboratory in concentrating sputum, urine, spinal fluid, body fluids and specimens of pus for the microscopic, cultural, and biologic demonstration of mycobacteria tuberculosis.

SPUTUM

There are numerous methods for concentrating sputum, all of which employ preliminary digestion of the contained protein by heat, enzymatic, or chemical action and subsequent centrifugation. Some techniques achieve greater sensitivity by chemical flocculation or hydrocarbon flotation for purposes of more complete removal of organisms from the digested specimen. Plain digestion is the simplest but least sensitive. Hydrocarbon flotation, the most time consuming and difficult, is the most sensitive. Chemical flocculation is uncomplicated and sensitive enough for general use.

Procedure: Equipment consists of 50 ml. round bottom centrifuge tubes without lip or spout, rubber stoppers, wooden racks to hold 50 ml. centrifuge tubes, small wooden centrally bored blocks to hold 50 ml. tubes upright at the patient's bedside, a Kahn shaking machine, 37.5 degree centigrade incubator or water bath, and a centrifuge.

Specimens are collected in 50 ml. tubes, in which the digestion is subsequently done. Not more than 15 ml. of morning sputum is required. It is most important that a specimen of sputum be obtained and not one of saliva or post-nasal discharge. If the quantity of sputum is small, 24, 48, or 72-hour collections may be made. Rubber stoppers prevent desiccation and contamination by foreign material. Names and pertinent data are written on a gummed label which is placed about the tube prior to distribution of the tube to the patient. In the laboratory the specimens are numbered, and the amount, type, and odor of the specimen are noted on a work sheet.

The method of digestion employed is that recommended by Hanks, Feldman, and Clark.[5] The fluid consists of sodium hydroxide as the digestant, potassium alum as the flocculating agent, but thymol blue has been substituted for bromthymol blue as the indicator. Acetic acid is used for neutralization rather than hydrochloric,

as there is a less crystalline debris.[6] Digestion fluid is added, the amount varying with the viscosity of the specimen, i. e., equal parts for serous or seromucoid specimens, and two to three times the amount for mucopurulent specimens. Rubber stoppers are tightly inserted, the tubes are then "racked", and the racks are shaken in the Kahn shaker for at least five minutes to assure homogeneity of the treated specimen. The tubes are then incubated for 30 to 60 minutes with occasional hand shaking to aid digestion. If culture or animal inoculation is anticipated, the incubation period is limited to 30 minutes as prolonged digestion decreases the number of viable tubercle bacilli.

After digestion is completed, the specimen is neutralized by the addition of sufficient acetic acid to give a pH of 8, at which point maximum flocculation of the potassium alum occurs. Do not add acid to the point of precipitation of the digested protein. Following a lapse of five minutes, during which the flocculation of the potassium alum becomes complete, the tubes are centrifuged at 3000 r.p.m. for 10 minutes. The supernatant fluid is carefully drained off into a sink designated as contaminated. The sediment is now ready for transfer to new halved glass slides. Numbered blocks painted upon the work bench make it unnecessary to number each slide and eliminate error in racking the smears.

In order to prevent the possible loss of part of the smear upon staining, with unlikely contamination of other slides in a common staining bath, each slide is treated with a small drop of Mayer's albumin-glycerin fixative, which is spread evenly over the slide prior to making the smear. Smears are made of the top portion of the sediment, using a new round wooden applicator stick for each specimen. The smear is permitted to air dry. Flame-drying is not done as overheating of the smear will disrupt the fatty-wax capsule of the bacillus with loss of its acid-fast properties. The smears are fixed by briefly passing the slides through a flame, care being taken that the slide is not over-heated. The smears are racked face forward, in sequence, corresponding to the tube-specimen number.

TABLE III

Type of Laboratory	No.	MICROSCOPIC					METHOD OF REPORT			
		Stain Technique			Slide Examination					
		Method Primary Stain	Counter-Stain	Method Staining	Microscopic Fields	Time Basis	Many Few Rare	Average No. per Field	Gaffky	As Positive
Public Health	9 labs.	Hot 7 Cold 2	Methylene Blue 9	Individ. 7 Bulk 2	4 25-300 fields per slide	5 3-5 minutes per slide	1	1	1	6
General Hospital	13 labs	Hot 6 Cold 7	Methylene Blue 11 Picric 1 Light Green 1	Individ. 10 Bulk 3	3 100 fields to entire slide	10 5-60 minutes per slide	6	1	1	5
Tuberculosis Hospitals	11 labs	Hot 7 Cold 4	Methylene Blue 9 Picric 2	Individ. 3 Bulk 8	5 100 fields per slide	6 5-15 minutes per slide	2	0	7	2

GASTRIC LAVAGE

This procedure, re-introduced by Delille in 1927,[7] is extremely valuable when there is little or no sputum production as in children, or for adults who refuse or are unable to expectorate, and for the final evaluation of patients ready for discharge. The lavage specimens, obtained in the morning before breakfast, are collected in chemically and bacteriologically clean 250 ml. Erlenmeyer flasks. The specimen is digested and neutralized as is done with sputum. Digestion should not be longer than 30 minutes. However, because the neutralized digest is larger in amount than that of sputum, the digest is trans-

ferred to two 50 ml. tubes for centrifugation. The sediment from one tube is used for culture and animal inoculation after resuspension in a few ml. of saline. The sediment of the other tube is used for making a smear.

On all initial diagnostic gastric lavage specimens it is necessary to do cultural or animal inoculation studies, preferably both, even though an occasional organism is demonstrated on the concentrated smear, because of the possible presence of saprophytic acid-fast organisms. Gastric lavage specimens, collected over a period of several days, should not be pooled and then treated as a unit. Recent work[8] has shown that there is an inhibitory substance, active even at refrigerator temperatures, in gastric lavage contents which inhibits partially or completely the growth of tubercle bacilli. Treatment, therefore, should be done the day the specimen arrives.

SPINAL FLUID

Two methods of concentrating spinal fluids are suggested, the choice of technique depending upon whether animal inoculation or culture is to be done. The first method[9] employs chloroform as the precipitant; this nullifies animal inoculation or culture. Two ml. of spinal fluid are shaken with 0.05 ml. of chloroform for 10 minutes, then centrifuged for 10 minutes at 3000 r.p.m., and the sediment smeared on clean slides. No fixative is employed. The second method,[9] for cultural or animal studies, requires that two ml. of spinal fluid be forcibly pipetted into 0.25 ml. of sterile one per cent aqueous solution of alum, then centrifuged for 10 minutes. Should there be sufficient sediment, a smear, using alum-milk fixative, may be done along with the biologic test.

URINE

Again, depending on whether smear alone or smear and biologic demonstration are to be done, the method will vary. For smear alone, 350-400 ml. of urine are placed in a 500 ml. "clean" volumetric flask, 4-5 ml. of toluene are added, then the flask is shaken for five minutes and water added to within one inch of the lip of the flask. The so treated specimen is permitted to stand undisturbed overnight, and smears are made of the creamy layer which forms under the layer of bubbles at the top of the flask on the following morning.[10] No fixative is used. For small volumes of urine, or for specimens obtained by bladder or ureteral catheterization, the technique of Hanks, Clark, and Feldman is employed.[11] Acetic acid is used to render the specimen acid, a few drops of thymol blue are added, and sufficient N/1 sodium hydroxide to make the specimen alkaline, pH 8, at which point the phosphates will come out of solution and precipitate. After a lapse of five minutes, the treated specimen is centrifuged, and a smear made of the sediment.

This method, however, fails to kill large numbers of secondary organisms, so that, if present, the sediment must be digested before culture or animal studies are done. For the treatment of 24-hour collections, the container is placed in the refrigerator overnight for sedimentation of the solids. The supernatant fluid is siphoned off, and the sediment is transferred to an Erlenmeyer flask. Digestion and neutralization are done as with gastric lavage material and the fluid centrifuged in two 50 ml. tubes, one for smear and the other, after resuspension in a small amount of saline, for biologic tests.

OTHER FLUIDS

Pleural, pericardial, joint and abdominal fluids are collected in sterile test tubes containing potassium oxalate as an anticoagulant. Sediment, obtained by centrifugation at 3000 r.p.m. for ten minutes, is used without fixative for smear and biologic studies. Cultures are also done for secondary organisms. Pus is usually smeared directly upon slides unless layering is apparent, in which case the specimen is centrifuged and the serous layer discarded.

STAINING AND MICROSCOPIC EXAMINATION

Staining is effected by placing the racked slides in a common carbolfuchsin staining bath at room temperature for a period of two to three hours. The slides are then drained of stain and placed directly into acid-alcohol, as washing in water before decolorization dilutes the mordant, phenol, and thereby decreases acid-fastness.[12] Decolorization is completed in a second bath of acid-alcohol in which the slides remain until the smears are faintly grayish-pink. The slides are then vigorously washed in running tap water, drained, and counterstained with picric acid for five seconds, washed in tap water, and dried.

Many workers prefer the hot staining methods to the cold because less time is required for staining and the organisms are stained more solidly. Heating, however, increases the amount of precipitated stain, requiring thereby prolonged decolorization of the slide and resultant decrease in acid-fastness of the organisms. Recently, it has been shown that by the use of a wetting agent, propylene glycol, the staining time for the cold method can be appreciably reduced to that comparable for the hot. This technique has not been sufficiently evaluated for general use.[13] Fluorescence microscopy for demonstrating tubercle bacilli, in this laboratory, has not proved to be specific.[14]

There has been some scepticism as to the significance of rare acid-fast bacilli seen on smears stained in a common staining bath, but Pottenger,[15] and Petroff and Schain[16] have

shown that the transfer of bacilli from one smear to another is highly improbable. Although not generally employed, the lighter counterstains, such as picric acid or light green, give superior results, for methylene blue tends to obscure the more delicately stained organisms.[15]

A slide is not considered as microscopically negative until 500 oil immersion fields have been examined, employing a 5X ocular. Slides are reported as positive or negative. The number of organisms present on a smear has no prognostic importance, as variations in number may be caused by factors entirely unrelated to the status of the patient, such as the manner and time of collecting the specimen and technique employed in making the smear. For those who prefer that the report give a rough indicaton of the number of bacilli found, it was suggested by the Committee on Evaluation of Laboratory Procedures of the American Trudeau Society that the terms numerous, few or rare be used instead of the Gaffky count:[17]

"Numerous: 10 or more acid-fast bacilli in every oil immersion field.

Few: 1-9 acid-fast bacilli in most immersion fields.

Rare: Single acid-fast bacillus found in an occasional oil immersion field."

Should three routine sputum specimens be negative on concentration, or at the most six specimens, there is little point in making more smears, as time and effort will be saved by resorting to culture and animal inoculation of concentrated material. Three or six negative smears of sputum concentrates should also indicate the necessity of examination of the sputum for fungi, neoplastic cells, and other bacteria. This is particularly true in those instances in which the patient expectorates large quantities of sputum negative for acid-fast bacilli. In addition, culture and animal inoculation provide more assurance in the early demonstration of organisms and remove the doubtful significance of an acid-fast organism demonstrated on the "umteenth" smear. The sediment obtained by concentration can also be examined, unstained, for fungi; however, it can not be used for fungus cultures.

BIOLOGIC DEMONSTRATION

Loewenstein's medium, one simply prepared[18] and one which supports luxuriant growth, is recommended. Substitution of one ounce screw cap bottles for culture tubes makes it possible to keep the medium in the refrigerator for periods of months without loss of moisture or contamination by fungi. Sputum, lavage material, urine, and fluids containing secondary organisms must be treated and concentrated prior to inoculation. The sediment of centrifuged body fluids, if secondary organisms are not present, is directly inoculated. At least two tubes should be inoculated.

For the cultural differentiation between human and bovine forms, tubes of glycerinated and non-glycerinated Loewenstein's medium should be inoculated. Saprophytic acid-fast organisms grow far more rapidly than pathogenic types and will grow at room temperature. After incubation, the tubes are examined at weekly intervals, at which time the screw caps are loosened and then lightly tightened. This prevents desiccation of the medium and provides sufficient oxygen for bacterial growth. Macroscopic evidence of initial growth is confirmed by microscopic examination of stained smears. Negative cultures are incubated for two months before being reported as "negative" after thorough microscopic examination of a stained smear made from surface scrapings of the medium.

Numerous reports emphasize the superiority of animal inoculation over cultural demonstration when done by the general technician. Yet those who are familiar with cultural methods state that animal inoculation is not superior and frequently is inferior to properly conducted cultural studies. Cultural studies are cheaper and the result is obtained more quickly. Ideally, both should be done. Animal inoculations, though, are the only certain method for differentiating human and bovine types, and for demonstrating pathogenicity. Guinea pigs, susceptible to both human and bovine forms, and rabbits, susceptible to the bovine form, are inoculated in the subcutaneous tissues of the groin or axilla. If successive specimens for animal inoculation are received, the same animal may be inoculated, since the cumulative action of multiple inoculations increases the possibilities of demonstrating tuberculosis by pig inoculation.[19] The animals are sacrificed at the end of two months if death has not intervened. Grossly positive results are confirmed by examination of stained smears of caseous lesions. Grossly negative animals, or those with equivocal lesions, are checked by the examination of tissue sections.

EQUIPMENT PREPARATION

All new glassware is washed in soap and water, immersed in chrome sulfuric acid cleaning solution for one hour, washed in running tap water, rinsed in distilled water, and then dried in the hot air sterilizer at 150 degrees C. for one hour. Contaminated glassware is first autoclaved and then subjected to the above procedure. New rubber stoppers are cleaned before use by boiling in 2 per cent sodium hydroxide until all extraneous matter is softened. Following this, the stoppers are scrubbed, rinsed in water, and stored in 95 per cent alcohol. Contaminated rubber stoppers are boiled in 5 per cent saponified cresol for 30 minutes, scrubbed,

washed in running water for three hours and stored in 95 per cent alcohol.

Contaminated Levine tubes, used for gastric lavage, are soaked in 5 per cent saponified cresol for 30 minutes and then effectively rinsed by forcing cold water through them under pressure. The Levine tubes are then boiled in 2 per cent sodium carbonate solution for 15 minutes, and while immersed in the warm solution the outsides of the tubes are well scrubbed with gauze sponges. Cold water is again forced through the tubes under pressure, and just before use they are boiled in a sterilizer for fifteen minutes.[7]

Only new glass slides are used. After microscopic examination the slides are destroyed. The expense entailed by such discard is minimized by the use of half slides for smears and by the value of the time spent in cleaning and preparing slides considered microscopically negative for re-use. Wooden racks and blocks, centrifuge cups, the work bench, and other objects possibly contaminated are cleaned by washing with 5 per cent saponified cresol, with subsequent air drying.

The above methods of cleaning objects contaminated by acid-fast bacilli, although apparently tedious, must be used regardless of the technique employed in examination of material for tubercle bacilli. Sterilization, although killing the organisms, does not destroy the acid-fast properties of all the bacilli. In addition, sterilization inspissates the bacilli-containing protein, making mechanical removal difficult; this material remains as a possible source of error on subsequent tests. For the same reason, only new glass slides are used. It is not an uncommon practice to reclaim microscopically negative slides by merely cleaning in soap and water, and finally, alcohol. Yet such slides, on a more thorough examination, might have been positive.

REAGENTS AND STAINS

Digestion fluid: 1000 ml. N/1 (4%) NaOH, 2 gm. potassium alum, 10 mg. thymol blue.

Neutralizing agent: 25% acetic acid.

Glycerinated Carbolfuchsin: 1 part basic fuchsin crystals, 10 parts 95% alcohol, 75 parts 5% phenol, 25 parts glycerin (minimizes precipitation of stain).

Dissolve the fuchsin in the alcohol as completely as possible using mortar and pestle, add the phenol, and filter. To the filtered stain, add the glycerin. Mix well. The stain is then ready for use.

Carbolfuchsin in Propylene Glycol: For rapid staining.

Solution A: 3 gm. basic fuchsin in 100 ml. propylene glycol.

Solution B: 5 gm. phenol in 100 ml. distilled water.

Solutions A and B are mixed in proportion of 1:4. Shake vigorously for several seconds. Staining solution stable for over 2 months at room temperature.

Acid-Alcohol: 3% hydrochloric acid, by volume, in 95% alcohol.

Picric Acid: 1% aqueous solution. Use hot distilled water to make solution easier.

Alum Solution for Spinal Fluid: 1% aqueous solution of potassium alum. Place in vaccine bottles and autoclave for 20 minutes at 15 lbs. pressure.

Alum-Milk Fixative: 5 gm. dehydrated skim milk (Difco); 0.5 gm. potassium alum; 0.5 ml. formalin; 100.0 ml. distilled water.

Loewenstein's Medium:

A. Mineral Salt solution: Anhydrous potassium sulphate, 1.2 gm.; Anhydrous magnesium sulphate, 1.2 gm. ($2.46 — 7\ H_2O$); Magnesium citrate, 0.3 gm.; Asparagin, 1.8 gm.; Glycerin, 6 cc.; Distilled water, q.s. ad 300.00 cc. Heat to dissolve; place in Arnold sterilizer at 100 degrees C. for 2 hours; allow to cool at room temperature overnight.

B. Starch solution: Put 15 gm. potato flour in a small beaker. Cover with filter paper or a watch glass and place in hot air sterilizer for 2 hours at 130 deg. C. Allow to cool. Pour this potato flour into the mineral salt slution. Heat over 56 deg. C. water bath, stirring frequently, for 1½ hours.

C. Egg Fluid: 12 clean hen eggs, less than a week old, are placed in 70% alcohol for 10 to 15 minutes. They are broken under sterile conditions into a sterile container and the yolk and white thoroughly homogenized by stirring or shaking in a mechanical mixer. The dozen eggs should yield approximately 500 cc. of egg fluid. Pour directly into the potato-flour-salt solution and mix thoroughly by shaking.

D. Add 10 cc. of a 2 per cent aqueous solution of malachite green. (Note—This malachite green solution should be made previous to using and allowed to incubate at 37 deg. C. overnight.) Mix thoroughly and filter through sterile gauze. Tube and slant. Place slanted tubes in inspissator at 50 degrees centigrade and run slowly up to 75 deg. C. (Or slant basket of tubes or bottles with loosened caps in Arnold sterilizer.) This should take about 1½ hours. Hold at 75 deg. for 15 minutes (or 1 hour if heat must penetrate baskets of tubes in Arnold). No further inspissation is necessary.

CONCLUSIONS

1. A limited survey of various types of laboratories in Ohio revealed inadequate employment of the sensitive methods for demonstrating tubercle bacilli.

2. A tuberculosis case finding program is being initiated by the Ohio Department of Health; it would, then, be advisable that the Division of Tuberculosis insist upon the routine employment of concentration and biologic methods for demonstrating tubercle bacille, by the various "public health" laboratories.

3. Tuberculosis hospitals should routinely do gastric lavage examinations and cultures on patients to be discharged.

4. Methods for demonstrating tubercle bacilli are presented for consideration.

BIBLIOGRAPHY

1. Sweany, Henry C.: The Underlying Principles and Minimum Standards of the Laboratory Examination for Tubercle Bacilli, Am. Jr. Clin. Path. 12, 459, 1942.
2. Pinner, Max: Pulmonary Tuberculosis in the Adult, C. C. Thomas, Springfield, Ill. 1945, page No. 362.
3. Edwards, Herbert R.: Tuberculosis Case-Finding, Supplement to Am. Rev. Tb. Vol. XLI, June, 1940.
4. Hospital Number, J.A.M.A. 127, 13:777, March 1945.
5. Hanks, J., Feldman, H., and Clark, H.: Concentration of Tubercle Bacilli from Sputum by Chemical Flocculation Methods, Jr. Lab. and Clin. Med. 23:736, 1938.
6. Robinson, Lenore, and Stovall, W. D.: Factors Influencing The Demonstration Of Tubercle Bacilli By Concentration Methods, Jr. Clin. and Lab. Med. 27:84, 1941.
7. Cited by Belgorod, S. H., and Schain, Philip: Pitfalls of the Gastric Examination For Tubercle Bacilli, Quart. Bull. of Sea View Hosp., 4:182, 1938-39.
8. Schwarting, Virginia: Inhibitive Effect of Gastric Lavage On Tubercle Bacilli, Am. Jr. Clin. Path. 15:234, 1945.
9. Hanks, J., Feldman, H., and Clark, H.: The Concentration of Tubercle Bacilli From Spinal Fluid by Means of Chemical Flocculation and Lipoid Solvents, Jr. Lab. and Clin. Med. 25:886, 1940.
10. Kelso, Richard E., and Galbraith, T. W.: A Rapid Simple Technic for the Detection of Tubercle Bacilli in Urine. Tech. Bull. of the Registry of Med. Tech. 4:1:8, January, 1943.
11. Hanks, J., Feldman, H., and Clark, H.: The Concentration of Tubercle Bacilli in Urine by Means of Phosphate Flocculation, Jr. Lab. and Clin. Med. 25:974, 1940.
12. Stampa, Henry C.: The Variations of the Tubercle Bacillus in Clinical Specimens. Am. Rev. of Tub. 22:443, 1930.
13. Randolph, Theron G., and Mikell, Robert F.: Carbol-Fuchsin in Propylene Glycol for Rapid Staining of the Tubercle Bacillus, Am. Rev. of Tub. 49:1:109, 1944.
14. Ritterhoff, Robert J., and Bowman, Miriam G.: Demonstration of Tubercle Bacilli by Fluorescence Microscopy. Am. Jr. Clin. Path., 9:No. 3:39-41, 1945.
15. Pottenger, J. E.: Controlled Staining of Mycobacterium Tuberculosis, Am. Rev. of Tub. 45:549-557, 1942.
16. Pottenger, J. E.: Counterstains in Demonstrating Mycobacterium Tuberculosis in Sputum, Am. Rev. of Tub. 45:5:558-567, 1942.
17. Committee on Evaluation of Laboratory Procedures, American Trudeau Society; Am. Rev. of Tub. 50:465, 1944.
18. Kelly, Ruby G., and Murphy, Eugene A.: Loewenstein's Medium—An Improved Method of Preparing It. Am. Rev. of Tub. 49:110-111, 1944.
19. Pottenger, Joseph E.: Serial Inoculation of Guinea-Pigs for the Demonstration of Mycobacterium Tuberculosis, Am. Jr. Clin. Path. 12:412-415, 1942.

The successful eradication of syphilis largely will depend on the early recognition of the infectious primary stage. For this purpose the darkfield examination of the suspicious lesion represents the diagnostic procedure of choice. Penicillin is the first therapeutic agent known to be effective against both gonorrhea and syphilis. The coincidental occurrence of these two diseases is by no means rare. The disappearance of spirochetes following the administration of penicillin is remarkably rapid and may occur as early as seven hours after the treatment is started. —Leon L. Blum, M.D., Terre Haute; The Journal of the Ind. State Med. Assn., Vol. 39, No. 6, June, 1946.

Iron Deficiencies

Causes: Since there is practically no iron excreted from the body there are only two essential causes of anemia from iron deficiency—blood loss and a deficient iron intake in youngsters whose growth causes an expanding need for iron. Since the female has a slight blood loss with each menstrual period, we would expect this type of anemia to be most common in females during the reproductive period. Experience, I believe, bears this out. Since it sometimes takes years to deplete the iron storehouses, however, this frequently does not appear until somewhat late in the reproductive period. In males, iron deficiency anemia always means blood loss; and in youngsters, especially from six months on, it may mean inadequate iron intake.

A deficiency of iron results in an anemia in which there is a reduction in the red count, but chiefly a defect in hemoglobin synthesis without much disturbance in maturation in the bone marrow, so that the peripheral blood shows a normochromic or slightly microcytic, hypochromic anemia. Platelets and leukocytes are unchanged. The reticulocyte count may be normal or may be slightly increased, reflecting the increased activity of the bone marrow.

The proper therapy of this entire group is, of course, iron. From what we now know about the metabolism of iron we can use it much more intelligently. In the first place there is at present no commercial iron preparation for parenteral use which will quickly or adequately raise the level of the iron storehouses. There are some experimental solutions, but so far these are unstable and dangerous to use. Since iron is ionized and absorbed in the ferrous state, the use of the ferrous iron, either sulfate or gluconate, has become almost universal. These give more available iron grain for grain than any other form. The older iron preparations, such as iron ammonium citrate, may be used if a sufficient amount is given to secure results. Even iron filling as used by our predecessors could still be used if we gave enough. The question of the addition of liver extract, Vitamin B, or amino acids to oral iron is an open one. While the work of Whipple and others would suggest that these substances are of value in shortening the time of return to normal of the blood, the only published statistical studies are on dogs. My impression is that they do have some benefit, but until the question has been carefully studied this is only an impression.

Copper seems to be purely catalytic in its action, and since most of our therapeutic iron contains some copper as impurity, the addition of this element is usually not necessary. In youngsters, however, whose response to iron is slow, the addition of copper may be necessary.—Marion F. Beard, M.D., Louisville, Ky.; The Journal of the Ind. State Med. Assn., Vol. 39, No. 7, July, 1946.

Tuberculosis Abstracts

A Review for Physicians Issued by the National Tuberculosis Association and Distributed by Component Society, the Ohio Public Health Association

THE SIGNING OUT OF TUBERCULOUS PATIENTS

Those who are interested in helping a patient to use the medical care necessary for recovery and to accept a possible physical limitation, find challenging problems in work with the tuberculous. The importance of this may be realized when hospitals in different parts of the country report that from 22 to 65 per cent of their patients leave "At Own Risk (A.O.R.)".

The patients who refuse all treatment have not been considered. The focus has been on patients who have evinced a desire to get well but who during the course of treatment attempted to terminate their recovery process. All hospital personnel, including the social worker, must accept: "It is never the body only which is out of health, but always the complete being." Often the reasons for leaving the hospital are obscure and great skill is needed to help the patient to be realistic and to direct himself toward the goal of complete recovery.

The treatment and hospitalization of patients with tuberculosis involves months or years of restricted activity. A young athletic boy, suddenly faced with tuberculosis, may revolt at accepting this state. Since the tubercle bacilli carry on their destructive work insidiously, the patient, after he has regained some strength, will insist that his cure is completed. This view is maintained despite the contrary evidence of X-rays and sputum reports. Perhaps the fear of the disease is so great as to cause the patient to reject its reality.

The older man and woman, accustomed to years of labor in factory and home, may also find it difficult to accept the new role of inactivity and dependency. Experience has not fitted them to fill the passing empty hours. The thought of lying quietly in bed while the world hurries on is untenable and they are tortured by the desire to be back among the working multitudes.

This boredom is more readily conquered by patients accustomed to study or reading, or those who are fortunate enough to have a hobby. Hospitalization is a difficult experience for the majority, but it can be a constructive one. Rarely does a patient who has found activities that lead to growth and development, sign out against advice. There is also a distinct difference between those patients who have made their adjustment and those who have succumbed to the sheltered life of the hospital and have regressed to an infantile, dependent level.

There does not appear to be any constant point at which a patient may feel that the hospital is no longer bearable. Even when individuals may be apparently adjusted to the hospital routine, the inactivity may lead to cumulative effects until a breaking point is reached. A little supportive treatment at this time will often tide the patient over the rough spot.

An individual entering a hospital brings with him the sum total of his life experiences. He has certain ties, certain obligations, and these remain though they are altered by the new experience. Early contact with the patient and his family can give clues to the patient's motivations and the part the family will play. The marital strengths, the interfamily ties and strains, the relationships in a changing setting should all be weighed and evaluated with the patient.

Life in a hospital is complex. A patient is faced with the need to adjust to his companions, the doctors, nurses, and other personnel. He has to give up practically all his privacy, both physical and mental. There are new ideas to be adjusted to in this microcosm of all nations and races. It is not difficult for friction to arise between the patient and a particular person or routine. Personalities may clash and the sick person may feel that the only solution lies in leaving the hospital. Sometimes the patient does not indicate the real reason for signing out but gives the usual statement that he "can do just as well at home". Other patients are quite verbose regarding the sources of annoyance.

An analysis (such as this abstract) can not give all the reasons why patients interrupt the treatment process. The individuality of every situation is marked, and therein lies the challenge. The problem is a big one. There has been a constant war against tuberculosis. In its earlier stages this fight was on a mechanical level of cleaning up slums, taking mass X-rays, or providing the proper type of hospital care. But now we have come to realize that we are dealing with human beings and the control of the disease will come only when the sick person is prepared to participate.—The Signing Out of Tuberculosis Patients, Jean Berman and Leo H. Berman, *The Family*, April, 1944.

Thiouracil complicates the surgeon's problems by increasing the vascularity of the gland and the tendency to bleeding at operation. This may be lessened by stopping the drug a few days before surgery and giving iodine for at least a week in advance of thyroidectomy.—Arnold S. Jackson, M.D., Madison; The Wisc. Med. Journal, Vol. 45, No. 7, July, 1946.

Industrial Commission Paid $3,335,267 for Medical Services During 1945, Report of Actuarial Section Reveals

THE State Industrial Commission disbursed $3,335,267.77 for medical services to injured Ohio workmen during 1945, according to a report issued recently by H. H. Pickering, Supervisor of the Actuarial Section. Included in that figure is a relatively small sum for dental services.

Other expenditures during the year included: $1,930,418.19, hospital care and nursing; $115,062.93, funeral expenses; and $73,442.08, court costs; a total of $5,454,190.97.

These amounts include payments covering treatment of injured private and public employees, as well as similar costs for occupational disease claims.

Comparative figures for 1944 were as follows: $3,412,675.60, medical services; $1,914,454.49, hospital care and nursing; $123,611.99, funeral expenses; and $67,332.68, court costs; a total of $5,518,074.76.

CLAIMS FILED DECREASE

The number of claims filed during 1945 was 250,630, 14.6 per cent less than in 1944. The average number of claims filed each working day was 905. There were 331,072 claims filed in 1943, the peak year in the 34-year history of the Ohio Workmen's Compensation Fund.

"Medical-only" claims, involving payment for physicians' services but no compensation to the claimant for loss of time, numbered 188,250 in 1945, or 75 per cent of all claims filed, compared with 76 per cent in 1944. The average fee for "medical-only" claims increased from $7.89 in 1944 to $9.14 in 1945.

AVERAGE COST INCREASES

The average cost of accident claims showed an increase of 21 per cent during 1945, the compensation cost increasing 19 per cent and the medical cost 29 per cent, according to the Actuary's report. These increases are attributed to increased weekly compensation and death benefits provided by the Legislature, and the revision of the Workmen's Compensation Fee Schedule which became effective May 1, 1945.

CONDITION OF FUND

Included with the Actuary's Report is a statement of the financial condition of the Ohio State Insurance Fund as of December 31, 1945. (Table 1.)

During 1945 the surplus of the Fund increased $6,041,684.36, resulting in a total surplus of $21,217,070.63. The total assets increased $9,242,070.18 to the amount of $143,643,651.25, the highest in the history of the Fund.

Following are some important excerpts from the Actuary's report for 1945:

RATES

"A study of the 1941-1945 experience indicates a reduction in rates of 13.4 per cent below the general level of last year. This is the greatest reduction that has occurred in any year for a number of years and is due principally to the high level of payroll affecting the rate computations and increasing the surplus of the Fund substantially over that of last year. Based on the premium volume for the past year it is estimated that the decrease will result in premium saving to employers of $3,350,000 during the next year.

"Both the accident and occupational disease rates for all classifications have been developed on the same basis as has been employed previously by confining our computations to the latest five-year experience occurring within the calendar years 1941 to 1945. Our analysis discloses that the basic rates which are composed of two portions, namely accident and disease, have shown a favorable downward trend, there being a decrease of 13.5 per cent in the accident portion and a decrease of 11.9 per cent in the occupational disease portion.

MERIT RATING

"Merit rating of employers' experience, since 1941, was done on the basis of combining the occupational disease experience with the accident experience. After June 30, 1946, merit rating of the occupational disease experience will be separate from the accident experience, thereby eliminating any effect that one may have upon the other.

"An analysis of Table 2 discloses that while the earned premium for 1945 was slightly less than that of 1941, the first year of the five-year period, the losses incurred in 1945 were correspondingly less. The losses for 1945 were $1,404,296 less than those of 1941 and the lowest of any year during the five-year period. In contrast to this difference in losses occurring in 1945 over those in 1941 is the comparatively little difference in earned premium, which in 1945 was only $321,739 less than in 1941. These factors are significant and an indication of the justification of the general reduction in rates this year."

"Table 3 discloses the current disbursements that have been paid for active claims distributed

TABLE 1

OHIO STATE INSURANCE FUND

(Workmen's Compensation)

FINANCIAL STATEMENT AS OF DECEMBER 31, 1945

*PRIVATE FUND

ASSETS

BONDS AT AMORTIZED VALUES		$137,559,889.41
State Treasurer's Bond Balance	$144,420,934.62	
*Less Public Fund	8,033,764.14	
Par value of bonds	$136,387,170.48	
Amortized value over par	1,172,718.93	
All bonds are in the custody of the State Treasurer and consist of obligations of the Federal Government and Ohio taxing districts.		
CASH		2,913,401.28
(Deposited with State Treasurer as Custodian)		
State Treasurer's Balance	$3,164,772.19	
*Less Public Fund	251,370.91	
PREMIUMS IN COURSE OF COLLECTION		2,509,203.36
(Less reserve for doubtful accounts)		
INTEREST ACCRUED		661,157.20
TOTAL ASSETS		$143,643,651.25

* The Ohio State Insurance Fund is separated by statute into two funds. The Private Fund covers employers in private industry, while the Public Fund covers the State, municipalities and other taxing districts.

LIABILITIES

RESERVE FOR COMPENSATION AND MEDICAL BENEFITS		$ 99,906,797.36
Reserve involved in merit rating	$ 44,744,600.00	
Reserve not involved in merit rating	55,162,197.36	
SAFETY AND HYGIENE FUND		1,044,496.43
RESERVE FOR CONTINGENCIES		8,534,142.86
To provide for possible depreciation of investments and other contingencies.		
OUTSTANDING WARRANTS		1,454,424.07
Warrants issued which had not been presented for payment to the State Treasurer by December 31, 1945.		
UNEARNED PREMIUMS		11,486,719.90
That portion of Advance Premium paid for coverage beyond December 31, 1945.		
SURPLUS		21,217,070.63
TOTAL LIABILITIES AND SURPLUS		$143,643,651.25

TABLE 2

COMPARATIVE INCOME, LOSSES AND EXPENSE

Year	Earned Premium	Losses Incurred	Investment Earnings	% Losses to Premium	Safety Expense
1941	$25,323,544	$22,650,750	$1,877,703	89.4	$154,573
1942	32,264,595	31,835,609	2,189,318	98.7	158,923
1943	33,360,118	30,193,423	2,667,109	90.5	179,959
1944	29,584,362	28,547,686	3,124,119	96.5	191,451
1945	25,001,805	21,246,454	3,139,729	85.0	234,855

according to year of injury and having injury dates in some instances reaching back to the beginning of the Fund. In addition to these disbursements, there has been a reserve of $99,906,797.36 established to meet benefit payments over many years in the future.

"The compensation benefit disbursements in the amount of $16,057,175 paid to injured workers or their dependents represented 75.7 per cent of the total disbursements, and medical, burial and court costs in the amount of $4,970,950 represented 24.3 per cent of the total disbursements of $21,219,353.

"The disbursements on current year claims in 1945 are 31.4 per cent. This has decreased from 44.7 per cent in 1943.

TABLE 3

1945 BENEFIT DISBURSEMENTS DISTRIBUTED TO YEAR OF INJURY OCCURRENCE

Total in 1945 for all years' accidents	Compensation	Medical, Hospital and Other Costs	Total	Per Cent
1945....	$ 3,808,529	$2,855,944	$ 6,664,473	31.4
1944....	3,503,803	1,456,001	4,959,804	23.4
1943....	2,487,641	371,019	2,858,660	13.5
1942....	1,445,638	136,221	1,581,859	7.4
1941....	1,022,339	77,650	1,099,989	5.2
1940....	714,420	59,847	774,270	3.6
1939....	443,697	16,917	460,614	2.2
1938....	313,260	24,128	337,388	1.6
1937....	321,248	28,183	349,431	1.6
1936....	175,180	13,452	188,632	.9
1912-1935	1,821,417	122,816	1,944,233	9.2
Total ...	$16,057,175	$5,162,178	$21,219,353	100.0
Ratios	75.7	24.3	100.0	

THIRTY-FOUR YEAR RECORD

"On March 1, 1946, the Ohio State Insurance Fund reached its 34th anniversary as a state-operated workmen's compensation carrier for Ohio employers.

"For the first year and ten months the Fund operated in competition with private insurance companies, and for the last 32 years has been operated as an exclusive fund in that private insurance companies have been prohibited from writing workmen's compensation insurance in Ohio.

"The record as to the accomplishments of the Fund from March 1, 1912, to December 31, 1945, is as follows:

Employers insured.....	181,161	(a)
Premium collected.....	$489,263,256	
Benefits disbursed.....	$399,633,093	
Interest collected.....	$ 59,515,222	(b)
Claims filed	6,100,408	

(a) Number of employers insured at some period or continuously over the 34 years.

(b) Interest earned on Fund investments used to pay benefits, thus obviating the necessity for premium in like amount.

RECENT YEARS GROWTH

Year	Employers Insured	New Claims Filed	Assets
1933	42,824	131,145	$ 40,167,624
1936	47,861	204,194	51,375,040
1943	60,492	331,072	128,299,916
1944	63,107	285,891	142,307,697
1945	67,529	250,630	151,969,266

"From the above it is disclosed that the assets of the Fund have shown a consistent growth since the year 1933 from $40,167,624 to $151,969,266.

"The number of new claims filed reached its peak in the year 1943 and during the years 1944 and 1945 declined to the extent of 80,442. This decrease is due principally to the number of medical-only claims filed which reached the peak of 269,249 in 1943."

Medical Research Society Formed

The National Society for Medical Research, a clearing house for information on medical studies and discoveries, has been organized under the sponsorship of the Association of American Medical Colleges with the cooperation of 101 national scientific organizations. Dr. Anton J. Carlson, President of the National Society for Medical Research and Professor Emeritus of Physiology at the University of Chicago, has announced the establishment of the Society's headquarters office at 25 E. Washington Street, Chicago. Ralph A. Rohweder, 1946 President of the Chicago Junior Association of Commerce and former consultant and editor for the National Safety Council, has been appointed Executive Secretary.

The society has as its purpose the advancement of research in medicine, biology, pharmacy, dentistry, and veterinary medicine. Dr. Carlson emphasized that an important function of the society is to analyze and expose the propaganda of small but highly vocal groups which object to the use of animals in the experiments without which medical science would still be in its infancy.

Hospital Rates Increased

By action of the Ohio Industrial Commission on July 1, the ceiling per diem patient day rate allowed hospitals contracting with the Commission was increased from $7.00 to $7.75 where X-ray services are excluded from the hospital contract, and from $7.25 to $8.00 where X-ray services are included in the contract. The Commission set a rate of $7.25 for out-of-state hospitals which do not operate under a contract with the Commission.

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

WHAT ARE YOU GOING TO DO ABOUT IT?

Both branches of organized labor are pledged to the support of measures similar to the Wagner-Murray-Dingell Bill, the basic philosophy of which conflicts with the economic, social, and governmental doctrines which have been found acceptable to the majority of Americans.

Both branches of organized labor are pledged to work for the election of candidates for Congress and for the various state legislative bodies who uphold the views of organized labor on this and similar issues.

None should quarrel with the right of organized labor to formulate its own policies on proposed legislation or to actively support this or that slate of candidates.

By the same token, none should question the right of those who oppose the W-M-D philosophy to work for the election of candidates who see eye to eye with them on this and similar issues.

There is a lot to be done between now and the November election by those who want personnel to their liking in Congress and in the Ohio General Assembly.

What are your views on these issues?

What are you doing or planning to do?

What do you know about the views and attitudes of the candidates from your county or district?

Have you considered going to work for those who are qualified, as you see it, to represent you in public office?

It's time for you to think over these matters —and get busy.

MANY LOCAL SOCIETIES NEED A SHOT IN THE ARM

"May we respectfully suggest that all members would do well to take a little more interest in the affairs of the Society?", is the plea of the president and secretary of a local county medical society in a Western state. Appearing in the society's monthly bulletin, the story was captioned "A Sad State of Affairs".

The society has a membership of 665. The officers were perturbed, and rightfully so. Only 38 members showed up at the society's monthly meeting. A number left at the conclusion of the scientific meeting. Consideration of official business had to be postponed for the lack of a quorum. It was the first time in 27 years that such a situation had occurred.

While this incident did not happen in Ohio, it does bring to our mind the actual fact that some of the county societies in this state need a shot in the arm. Some are not meeting regularly, if at all. At some meetings the attendance has been poor.

Granted: Membership was depleted during the war and the men left at home had little time for meetings. But most of the medical officers have returned to civilian practice. Conditions generally are approaching normal. Many men are starting practice for the first time.

The county medical society is the hub of medical organization. It can be—and in many counties, is—a powerful influence of good for the medical profession, as well as for the community at large.

If you agree—and we think you do—how's for attending that next meeting of your society? If your society has been on inactive status, tell the president or secretary that a call to active duty is very much in order. This Fall would be a good time to resume regular meetings.

World War II is over, but the medical profession still has a fight on its hands. The result of that fight will be "A Sad State of Affairs", unless all members "take a little more interest in the affairs of the Society".

HOW MUCH DO YOU KNOW ABOUT THESE PROGRAMS?

A recent report of the Ohio Division of the American Cancer Society shows that $305,000 was donated by the people of Ohio during the membership and fund-raising campaign of the organization last Spring.

It is understood that approximately twice that much was donated by Ohioans to the Ohio branch of the National Foundation for Infantile Paralysis.

There are other similar groups which annually receive substantial contributions from the people of Ohio to carry on their programs locally and on a national scale.

The fundamental purposes of these organizations are good. Their activities to date have been beneficial to many and beyond justifiable criticism. Administrative policies and procedures have been supervised by sound-thinking persons who have been guided by the advice of competent members of the medical profession.

Will this situation continue? There is no valid reason to believe that it will not. However, a swollen treasury is the forerunner to expansion of activities. Obviously, no objection

NEW

SEARLE AMINOPHYLLIN SUPPOSITORIES



For more convenient and effective rectal administration of Aminophyllin,* Searle Research has produced

AMINOPHYLLIN SUPPOSICONES
(SEARLE BRAND OF AMINOPHYLLIN SUPPOSITORIES)

Differing from all other types of suppositories, Searle Aminophyllin Supposicones are molded with a new base material which liquefies rapidly in the rectum, permitting complete absorption of the Aminophyllin, but which remains *stable and solid at temperatures up to 130° F. outside the body.*

Searle Aminophyllin Supposicones are non-irritating to the rectal mucosa—require no anesthetic—are of proper size and shape for easy insertion and retention. Each Aminophyllin Supposicone contains 500 mg. (7½ grs.) Searle Aminophyllin. Packaged in boxes of 12.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

*Searle Aminophyllin contains at least 80% of anhydrous theophyllin

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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

can be raised to expansion providing fundamental principles and sound practices are observed.

How much do you as a member of the medical profession and as a citizen know about the activities of the various voluntary medical-health-welfare groups which are carrying on programs in your community?

Is your local medical society taking an active, direct interest in such programs? Has it been asked to supply professional guidance? Has it been consulted about future plans?

If hundreds and thousands of dollars are going to be spent in your community on medical and health programs, wouldn't it be wise for you to know how the money is to be expended; and on what? Wouldn't it be wise for you to help guide the expenditure of these funds; to keep activities from getting out-of-bounds and in a snarl?

Think it over.

NEED FOR MORE G.P.'s A GRAVE PROBLEM

The charge that the importance of specialization is being over-emphasized and that of general practice de-emphasized, would appear to be borne out by a check of the desires and attitudes of younger physicians, many of them ex-servicemen, who are laying their plans for the future.

The majority of the men who have inquired about openings and locations in Ohio indicate a desire to enter practice in some specialty. Many others are entering residency in one of the specialties.

Something must be done to check this trend. It is a question which warrants the serious consideration of medical educators and medical societies. Unless something is done—and soon—the very heart of medicine will be vitally affected.

During the war, the shortage of general practitioners created a critical problem. Today, there are many areas—communities which can support one or several general practitioners, and well—which are issuing urgent appeals for a G.P.

The net result of this trend is that many young doctors are overlooking a good bet; many communities are woefully short on medical personnel; more economic waste is being created through specialized care for routine conditions; and specialists, in the long run, will lose, for the G. P. is their chief source of referrals.

Joint action to sell the medical graduate on the importance, opportunities, and benefits of general practice, and to encourage communities to take steps which will make general practice more attractive is called for.

The Committee on Rural Health of the Ohio State Medical Association is giving this question considerable attention. What are your views and suggestions? The committee would welcome them.

"SO SORRY", SAYS THE GENTLEMAN FROM FLORIDA

Several weeks ago U. S. Senator Claude Pepper released to the press a story which gave the impression that the Senate Committee on Education and Labor has submitted a report which endorsed pending compulsory health insurance legislation.

Actually the facts on which the release was based are as follows:

1. The report was a report of a sub-committee.
2. The report was signed by only four of nine members of the sub-committee.
3. The report was written in March, 1946, before hearings on pending legislation had begun.
4. The report had never been submitted to the Committee on Education and Labor for action.

When asked to explain, Pepper answered: "I am exceedingly sorry that inadvertently such a thing may have occurred."

The explanation of the gentleman from Florida relieves us no end as we had "inadvertently" concluded that he was just trying to slip over another fast one—or did he?

HIGH SCHOOL, COLLEGE STUDENTS TO DEBATE MEDICAL CARE

"Resolved: That the federal government should provide a system of complete medical care available to all citizens at public expense."

This subject has been selected by the Committee on Debate Materials and Interstate Cooperation of the National University Extension Association as the proposition to be debated in high schools and colleges during the next school year.

Hundreds of high school and college students in Ohio will be seeking material on the subject. It is hoped that all of them will go to members of the medical profession for facts and opinions.

Are you prepared to discuss this subject with Mary Jones or Bill Smith?

Do you have material on this subject which you can lend to them for study?

Are the school officials of your community planning to encourage students to consult with local physicians on this matter? If not, why not? Have you, or a committee of your local medical society, discussed this with the school authorities?

Better get the answers to these questions now. You better be prepared as the younger

FACTS ABOUT THE PREPARATION OF



Campbell's STRAINED BABY SOUPS

Q. How are meats prepared for the soups?

A. The full protein and other nutritive values in meat are available only when the meat solids as well as the juices of meat are used. Campbell's method of comminuting the meat—superior to the "scraping" common in home use—assures that all the edible solids as well as all the juices are included. Four of the Campbell's Strained Baby Soups have a meat base: Chicken, Liver, Lamb and Beef.

Q. How early may these soups be started?

A. That depends entirely upon the individual baby and the physician's judgment. However, these soups are intended for use as early as any strained baby food. The soups are not seasoned (except for light salting) and are of smooth texture and uniform consistency. A comprehensive analysis of each soup may be had upon request to Campbell Soup Company, Camden, New Jersey.

Q. How are vegetables prepared for the soups?

A. Both the flavor and the nutritive values of vegetables naturally depend in great part upon the way they are handled and cooked. Campbell's have developed a method, based on the latest scientific knowledge, which retains the minerals and efficiently conserves the vitamins, as well as the wholesome natural flavors.

5 KINDS:

LIVER
CHICKEN
LAMB
BEEF
VEGETABLE

All in Glass Jars



Campbell's Strained Baby Soups represent fine quality . . . in ingredients . . . in care and method of cooking . . . in retention of minerals and conservation of vitamins . . . *and in good flavor.* Every resource of Campbell's Kitchens is devoted to that aim.



LOOK FOR THE RED-AND-WHITE LABEL

generation becomes impatient rather quickly and doesn't tolerate the ring-around.

If you need help, or Mary or Bill of your town need help, drop a line to the Department of Public Relations of the Ohio State Medical Association. It can, and will be glad to, supply material.

LET THE FANATICS PAUSE AND THINK!

The discovery of insulin 25 years ago by Best and Banting will be commemorated this Fall by programs on diabetes at various medical centers.

Celebration of this event which has been instrumental in saving and prolonging the lives of countless persons should cause those who so vigorously oppose the use of animals in medical research to pause and think. The discovery of insulin and the benefits of its use are typical examples of the good accruing from controlled scientific experimentation.

We dare not permit the hysterical crusading of fanatics to impede the progress of medicine.

SAME OLD DE KRUIF, SAME OLD INACCURACIES

Those who have been fed up for too long with the silly and inaccurate rantings of Paul de Kruif in popular magazines will get a kick out of the spanking he received in the following letter by H. J. Anslinger, U. S. Commissioner of Narcotics, to the Editor of *The Journal of the A.M.A.* and published in the July 13 issue of that publication. No comment on our part appears to be necessary as Anslinger's letter speaks a mouthful. To quote:

"**To the Editor:**—You were the first to call my attention to the new drug Dolantin, which was discovered in Germany and which made its appearance several years ago in the Argentine. You also called my attention to the fact that both countries had immediately placed this drug under strict control. You ventured the suggestion that the drug would make its appearance in the United States and probably had addiction liabilities similar to morphine. Your prediction was correct. The drug was introduced in the United States under the name Demerol. Its addiction properties were found to be similar to morphine by the United States Public Health Service Hospital at Lexington, Ky., where scientific studies in this field are the best in the world. This was confirmed by others who experimented with the drug.

"Now comes an article by Paul de Kruif in the June issue of the *Reader's Digest* entitled 'God's Own Medicine—1946' under the heading 'The pain-fighting power of demerol is as miraculous as that of morphine—without the opiate's danger of addiction.' This article adroitly makes no reference to the work of Dr. C. K. Himmelsbach of the United States Public Health Service and Drs. Hans H. Hecht, Paul H. Noth, and F. F. Yonkman of Detroit, all of whom warned of the danger of addiction.

"Demerol was placed under federal narcotic control by the Congress because of evidence given before that body of its dangerous properties. Some of the persons referred to in de Kruif's article could have attended the hearings before the Ways and Means Committee and have testified as to what they thought about the drug, but they elected to remain quiet.

"I fear a wave of Demerol addiction if physicians who read this article believe what I consider the reckless and dangerous statements made by de Kruif that the drug is free from addiction properties. There is information somewhat similar to that which appears in the circular distributed by the manufacturer of Demerol to push sales. Had this article been prepared on a strictly scientific basis it would have sounded a strong warning about the danger of addiction. Our files contain numerous cases of addiction involving the use of Demerol. I can not too strongly warn the members of your Association about the danger of addiction of Demerol."

REBATES, ETHICS, AND MEDICAL SOCIETIES

The public relations of the medical profession got another jolt recently when the U. S. Department of Justice filed charges against certain optical firms and certain physicians as representatives of a group of physicians, charging them with violation of the Sherman Act.

The physician defendants were charged with a part in the alleged fixing of prices through the acceptance of rebates from the opticians.

Not nice publicity, was it?

The acceptance of rebates is a violation of the Principles of Medical Ethics of the American Medical Association. Doubtlessly some of the physicians who have engaged in such practices are members of organized medicine and know this. Rather unfortunate, isn't it, that their local medical societies didn't beat Uncle Sam to the draw by taking disciplinary action long ago.

As long as medical organization permits unethical and shady practices to continue by default, it can't hope to improve its public relations, for in the final analysis the entire medical profession is going to be judged by the actions and practices of its individual members.

What your fellow practitioner does is your business, don't forget that. You may not think so but you, as a part of all the physicians in your community, can't escape the reflected honor or dishonor which the doctor across the street acquires.

Are rebating and other unethical practices being tolerated in Ohio?

What do you think?

Dayton—Dr. Bert Krug has been re-elected chairman of the Metropolitan Health Council. The new vice-chairman is Dr. N. E. Leyda, who succeeds Dr. Mack Shafer. The latter was named a member of the board of directors of the Council of Social Agencies.



Alice had it easy

We've come to appreciate Alice's feelings in "Through the Looking Glass" when the Red Queen said,

"...it takes all the running you can do, to keep in the same place. If you want to get somewhere else, you must run at least twice as fast as that!"

But we find ourselves in an even more trying predicament.

Production of AMINOIDS* is up more than 100% over last year and still we are not able to keep up with the demand.

We are improving and extending production facilities as rapidly as post-war conditions permit. Meanwhile we are trying to distribute our output as equitably as possible. We hope we shall soon be able to fill every order promptly. Your understanding of our predicament and your continued friendly cooperation will be appreciated.

*The word AMINOIDS is a registered trademark of The Arlington Chemical Company.

THE ARLINGTON CHEMICAL COMPANY

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Fate of Ohio Veterans Medical Care Program Hinges on Judgment Used in Making Authorizations for Services By "Home-Town" Physicians of Veterans' Choice

TWO-MONTHS' experience indicates that the success of the Ohio State Medical Association's Veterans Medical Care Program, designed to permit veterans with service-connected disabilities to use the services of "home-town" physicians, will depend to a large degree on whether sound judgment and reasonable discretion are used by the managers of Ohio regional and sub-regional offices of the Veterans Administration in making authorizations for examination and treatment.

When the agreement between the Ohio State Medical Association and the Veterans Administration went into effect on July 1, 1946, the program was widely publicized through releases distributed by the Veterans Administration, through material mailed by the Ohio State Medical Association, and in publications of the various Veterans' Organizations.

INTENT AND PURPOSES

This publicity emphasized that the program was in line with the goal of General Paul R. Hawley, medical director of the Veterans Administration, namely to bring about a close working arrangement between thousands of physicians in private practice and the Veterans Administration.

It was pointed out by the Ohio State Medical Association that the program would provide veterans with the best of medical attention; would give them the opportunity to use the services of their family physicians or other physicians in private practice; would make it unnecessary for the Veterans Administration to establish extensive out-patient facilities with full-time staffs; would give present Veterans Administration facilities an opportunity to concentrate on aiding veterans who need hospitalization or care which can best be provided in an institution; and would permit such facilities to use their personnel for pension-rating examinations.

As of August 14, a total of 4,062 Ohio physicians in private practice had signed up as fee-designated physicians under the Ohio Program, giving disabled veterans in practically every county an opportunity to receive examinations and treatments from "home-town" doctors.

WANT CLINICS USED

However, soon after the program became effective, reports were received by the Ohio State Medical Association that a number of regional and sub-regional offices of the Veterans Administration, when asked to make authorizations for examination or treatment, were insisting that the veteran report to one of the out-patient clinics of the Veterans Administration for services.

Obviously, this procedure was in conflict with the Ohio State Medical Association's understanding of the purposes and intent of the Ohio Program and the agreement upon which the plan is based. The fact that the refusals related to cases in metropolitan areas where the greatest number of veterans with service-connected disabilities reside added additional complications.

RULING REQUESTED

At the request of physicians who wanted to know how the Ohio Program was to be administered and interpreted and whether or not they should continue as fee-designated physicians, and because some veterans expressed dissatisfaction when refused the right to visit their own physicians, the Ohio State Medical Association asked Branch Office No. 6 of the Veterans Administration, Columbus, for an official statement on the problem.

Branch Office No. 6 submitted the question to the solicitor of the Central Office of the Veterans Administration, Washington. Based on a reply received from the Central Office, the Columbus office on July 17 issued the following communication:

REPLY OF BRANCH OFFICE

"Ohio State Medical Association
79 E. State Street
Columbus, Ohio

"Gentlemen:

"In accordance with your verbal request concerning the agreement between Veterans Administration and the Ohio State Medical Association for the medical care of veterans with service-connected disabilities, you are advised that the agreement is to supplement the facilities of our Clinic in the Regional and Sub-Regional offices located in the State of Ohio.

"Veterans entitled and in need of out-patient treatment and living in a city or area covered by a Veterans Administration Clinic should be referred to that clinic for treatment. Veterans Administration operative clinics should be used to the limit of their capacities. However, wherever it is found that it works a hardship for a veteran to report to a clinic located in the area where the veteran lives he then may be furnished treatment if eligible through a physician closer to his home."

LETTER SENT GENERAL BRADLEY

Judging this ruling unsatisfactory and conflicting with the spirit and purposes of the

"...Unto the Third and Fourth Generation..."



PROTECTION against congenital syphilis can often be accomplished by treatment of the expectant mother.

Proper antisyphilitic therapy during pregnancy can prevent or control syphilis in the infant . . . lower the mortality rate in fetal syphilis . . . reduce the frequency of premature labor—even if the antisyphilitic course is comparatively short and the child not cured. Syphilis in mothers can be well started toward symptomatic and serologic cure.

MAPHARSEN (meta-amino-para-hydroxyphenyl arsine oxide (arsenoxide) hydrochloride) gives maximum therapeutic effect—rapid disappearance of spirochetes and prompt healing of lesions. Minimal untoward reactions are less severe than those observed after use of arsphenamines.



MAPHARSEN

PARKE, DAVIS & COMPANY
DETROIT 32, MICHIGAN

agreement with the Veterans Administration—at least as understood by officials of the Ohio State Medical Association—Dr. E. P. McNamee, President, and Dr. H. V. Paryzek, Chairman, Committee on Medical Care of Veterans, instructed the Executive Secretary to write General Omar N. Bradley, Administrator of Veterans Affairs.

TEXT OF COMMUNICATION

Following is the text of the communication sent to General Bradley on July 19:

"General Omar N. Bradley
Administrator of Veterans Affairs
Veterans Administration
Washington, D. C.

"Dear General Bradley:

"Complying with instructions from Dr. E. P. McNamee, Cleveland, President of the Ohio State Medical Association, and Dr. Harry V. Paryzek, Cleveland, Chairman of the Committee on Medical Care of Veterans of the Association, I am writing you to respectfully request your prompt and earnest consideration of a serious problem which has arisen here in Ohio and which threatens to severely handicap the cooperative program between the medical profession of this state and the Veterans Administration.

"As you undoubtedly know, on July 1 an agreement between the Veterans Administration and the Ohio State Medical Association, establishing a program whereby veterans with service-connected disabilities could receive good medical care promptly from their family physicians, became effective. A copy of the agreement is attached.

"As of today 3,715 Ohio physicians have agreed to serve as fee-designated physicians under the program. These names have been certified to the Veterans Administration and have been placed on the approved list. Additional names are being added almost daily.

"Our relationship with Branch Office No. 6 of the Veterans Administration, serving the States of Ohio, Michigan, and Kentucky, has been splendid. We have received fine cooperation and assistance from Deputy Administrator Stone and all of his officials.

"However, shortly after the program went into effect in Ohio, it was reported to us that several of the administrators of the regional and sub-regional offices here in Ohio, notably in the Cleveland area, refused to authorize the care of disabled veterans by the family physicians or physicians of the veterans choice in areas in which a regional out-patient dispensary is in operation. These administrators contend that the Ohio State Medical Association program is intended only to supplement the dispensary services already established by the Veterans Administration.

"This question was discussed immediately with officials of the branch office. Attached you will find a copy of a communication dated July 17 on this matter. We understand that this communication is based on advice received from the solicitor of the Central Office of the Veterans Administration, Washington.

"It is our opinion that if this policy is to be followed most of the beneficial effect of the program which has been worked out by this Association and approved by the Veterans Administration will disappear. Undoubtedly the greater number of veterans with service-connected disabilities reside in the metropolitan areas. We understand that most of the metropolitan areas have established some sort of out-patient dispensary. If these dispensaries are going to handle all of the out-patient medical services for veterans, obviously veterans in those areas will not be given any opportunity to select their own physician or their family physician for medical services. This means that a large number of the physicians whose names have been certified to the Veterans Administration will not be given an opportunity to look after former patients or veterans who desire to use their services instead of the Veterans Administration dispensary services. For your information the following numbers of physicians have signed up in the metropolitan areas of Ohio: Cleveland, 777; Columbus, 302; Cincinnati, 471; Toledo, 219, Youngstown, 136; Dayton, 170; Canton, 131; Akron, 173.

"This policy conflicts with the understanding of the officials of the Ohio State Medical Association with respect to the program which has been established by the Association with the approval of the Veterans Administration. We believe that it is contrary to the intent and purposes of the program. Moreover, we believe that it is contrary to the intent and purposes voiced on many occasions by General Hawley on the matter of medical care of veterans with service-connected disabilities.

"As you know, General Hawley has stated quite frankly that he believes it will be necessary to use physicians in private practice in order to provide veterans with the best of medical care and he has encouraged state and local medical societies to establish programs whereby veterans can make use of the services of their own physicians.

"In line with General Hawley's views, this Association prepared its program and submitted to the Veterans Administration and it was subsequently approved. The underlying purposes were:

"1. To bring as many physicians in private practice as possible into the medical care program of the Veterans Administration;

"2. To give all disabled veterans an opportunity to select their family physician or some other physician in private practice;

"3. To make it unnecessary for the Veterans Administration to establish extensive out-patient facilities and to maintain large staffs of medical personnel for out-patent services;

"4. To give the Veterans Administration an opportunity to concentrate on services which must be rendered by Veterans Administration hospitals; and to use its limited personnel for these more important services rather than for out-patient work.

"We fully realize that the administrators of the regional and sub-regional offices must have discretionary authority. We realize that on certain cases it will be necessary for them to have a veteran report to a Veterans Administration Facility for a checkup or confirming examination.

"However, we feel that the real purposes of our program will be defeated if the veterans in many areas of Ohio are made to report to Veterans Administration dispensaries for care and are given no opportunity to select their family physician or some other physician as contemplated in the Ohio plan.

"Our program has received widespread publicity in the newspapers of Ohio and in the publications of veterans' organizations. A release from the Public Relations Department of the Branch



STAPHYLOCOCCUS TOXOID
PITMAN-MOORE

AMONG the many conditions which especially enlist the sympathy of the physician—and tax his efforts to ameliorate the psychic as well as the somatic symptomatology—are boils and acne.

A growing literature reports the value of Staphylococcus Toxoid in the prophylaxis and therapy of various staphylococcic pyodermas and localized pyogenic processes due to *S. aureus* and *albus.* The toxoid induces the production of staphylococcus antitoxin in immunized persons, and there is accumulating evidence of its value in producing active immunity to the dermonecrotic and hemolytic elements of the toxins of *S. aureus* and *albus,* irrespective of the strain of the infecting organism.

Staphylococcus Toxoid (Pitman-Moore) is supplied in 5 cc. vials containing in each cubic centimeter the toxoid derived from 1,000 necrotizing doses of the toxin. Preserved with 1:10,000 sodium ethyl mercuri thiosalicylate. Comprehensive information with each package.

RECOMMENDED FOR TREATMENT AND PREVENTION OF

- Recurrent styes, boils, carbuncles
- Pustular acne associated with furunculosis
- Recurrent migratory staphylococcus abscesses of soft tissues and bone
- Staphylococcal infection of accessory nasal sinuses
- Other staphylococcal infections

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PITMAN-MOORE COMPANY

PHARMACEUTICAL AND BIOLOGICAL CHEMISTS

Division of Allied Laboratories, Inc., • Indianapolis 6, Indiana

Office here in Ohio was played up in most of the Ohio newspapers. I am enclosing several clippings as samples. You will note that great emphasis is placed on the fact that veterans will be able to receive treatment from home-town physicians. If this intent is to be nullified in the metropolitan areas of Ohio, you can readily understand that physicians as well as veterans will become dissatisfied and we fear that the entire program may collapse.

"Obviously, we are just as much interested in preventing this as the Veterans Administration, veterans, or anyone else and for this reason, with the full approval of Deputy Administrator Stone of the Branch Office here in Ohio, we are laying the facts before you.

"It is our earnest hope that you will be able to work out a modification of what seems to be the policy which will be pursued by some of the regional offices in such a way that our program can function along the lines of its original purposes and intentions.

"Inasmuch as this is a question which should be clarified as soon as possible because of the widespread publicity which has been given to the program, we hope that you will give this matter immediate attention.

"The officials of this Association and the medical profession of Ohio generally are extremely enthusiastic in their desires to cooperate to the fullest extent with you, General Hawley, and all officials and offices of the Veterans Administration. The doctors of Ohio feel that they can be of great help to you as well as to disabled veterans. We feel that the underlying principle whereby disabled veterans can receive care from home-town physicians is medically and economically sound. For these reasons, we would hate very much to have anything occur on a permanent basis which would nullify or handicap the operation of our plan."

GENERAL BRADLEY'S REPLY

This communication was acknowledged by General Bradley under date of August 1. His letter read as follows:

"Mr. Charles S. Nelson,
Executive Secretary,
Ohio State Medical Association,
1005 Hartman Theater Building,
Columbus 15, Ohio.

"Dear Sir:

"Reply is made to your letter of July 19, 1946, relative to the operation of the agreement between the Ohio State Medical Association and the Veterans Administration for out-patient treatment and examinations for pension and compensation purposes of veterans residing in the State of Ohio.

"The following information is furnished you, as it is believed it will assist in clarifying the situation you present, and give an over-all picture of our out-patient problems.

"Immediately following my becoming Administrator of Veterans Affairs, it was evident that our full time Clinics in our Regional Offices and Sub-Regional Offices then in operation, and new ones to be opened, would not be adequate to meet the ever increasing out-patient load, nor could sufficiently trained medical personnel, covering the various Specialties of Medicine and Surgery, be obtained on a full time or part time status. It was also evident that physicians in private practice would not be able to devote sufficient time from their professional duties and responsibilities to handle all of the Veterans Administration out-patient examination and treatment load. However, it is believed that we will be able to render to all eligible veterans the prompt and efficient service they so richly deserve through the services of civilian physicians in conjunction with our own Out-patient Clinics.

"As you can readily appreciate, the facilities of our own Clinics must, of necessity, be utilized to their fullest extent. However, it is not my desire or intention to arbitrarily order veterans to a Veterans Administration Clinic, if such action would work a hardship on them, or cause them to lose unnecessary time from their work. Veterans residing in metropolitan areas will be permitted to secure treatment through local physicians, if it is found to be more expedient and satisfactory to do so. In making a determination as to whether a veteran living in a city where one of our Clinics is located should be referred for treatment to the Clinic or to a local physician, consideration will be given as to which procedure is to the best interests of the veteran, and the Government.

"There is at the present time a back-log of approximately 13,000 cases in Ohio pending examination for pension purposes, a considerable percentage of which will, when adjudicated, be entitled to treatment for service-connected disabilities. Accordingly, instructions have been issued to Mr. Ralph Stone, Deputy Administrator, Veterans Administration Branch Office No. 6, Columbus, Ohio, to utilize the services of Ohio State physicians to the fullest extent, both in metropolitan and rural areas, in clearing up the back-log of pending examinations. Following the initial adjudication of the pending claims, a very large percentage of the service-connected cases may be referred to physicians of the veterans' choice for continued treatment. This will permit the Out-patient Clinics of our Regional and Sub-Regional Offices to concentrate their efforts in rendering expeditious service in those cases, which present a diagnostic problem, or in which the adjudicating agencies desire complete examinations by our own full time or part time specialists, in order to properly evaluate the veteran's degree of disability.

"You may be assured that the splendid cooperation of the Ohio State Medical Association is very much appreciated.

"Please do not hesitate to advise me in the event you encounter any further difficulties in carrying out the terms of our agreement, or in making the Ohio Plan a success."

CONFERENCE WITH MR. STONE

These communications were discussed with Mr. Ralph H. Stone, deputy administrator, Branch Office No. 6, Columbus, with whom the situation had been discussed early in July and who had readily approved the Association's suggestion that it write General Bradley direct for interpretation and clarification of the problem which threatened to nullify to a large extent the operation of the Ohio Program.

After reviewing General Bradley's letter to the Ohio State Medical Association and communications which he had received from both General Bradley and General Hawley on this subject, Mr. Stone on August 13 sent the fol-

Benzedrine Inhaler, N.N.R.
"... is quite effective in the clearing of nasal congestion due to allergy or infection"

Feinberg, S. M.: Allergy in Practice,
Chicago, The Year Book Publishers, Inc., 1944, p. 502.

Your hay fever patients will be grateful...particularly between office visits...for the relief of nasal congestion afforded by Benzedrine Inhaler, N. N. R.
The Inhaler may make all the difference between weeks of acute misery and weeks of comparative comfort.

Each Benzedrine Inhaler is packed with racemic amphetamine, S.K.F., 250 mg.; menthol, 12.5 mg.; and aromatics.



Benzedrine Inhaler
a better means of nasal medication

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Smith, Kline & French Laboratories, Philadelphia, Pa.

lowing communication to the managers of the Regional Offices in Ohio, with instructions that they bring it to the attention of all sub-regional and contact offices:

TEXT OF LETTER TO MANAGERS

"Manager
Veterans Administration Regional Office
230 East Ninth Street
Cincinnati, Ohio

"Dear Sir:

"The following information is furnished you in order to further clarify the agreement between the Veterans Administration and the Ohio State Medical Association.

"In view of the backlog of examinations for pension and compensation in the State of Ohio, it is suggested that the offices under your jurisdiction be directed to immediately take advantage of the agreement with the Ohio State Medical Association, in order to clear up the backlog at the earliest moment, and in order that formal rating action may be taken. By utilizing the services of the Ohio State physicians to the fullest extent, both in metropolitan and rural areas, you should be able to clear up the backlog of pending examinations within a reasonable time.

"In addition to utilizing the services of civilian physicians in rendering treatment to veterans residing in rural areas, veterans residing in metropolitan areas should also be permitted to secure treatment through local civilian physicians, if it would be more expedient and satisfactory to do so. In making a determination as to whether a veteran, living in a city where one of our Clinics is available, should be referred for treatment to the Clinic or to a local physician, consideration should be given as to which procedure would be to the best interests of the veteran and to the Government. While it is our desire that the facilities of our own Clinics be utilized to their fullest extent, it is not desired to arbitrarily order veterans to a Veterans Administration Clinic, if such action would work a hardship on them or cause them to lose unnecessary time from their work.

"Following the initial adjudication of the pending claims, a very large percentage of service-connected cases may be referred to physicians of the veterans' choice for continued treatment. This will permit your office as well as your sub-regional offices to concentrate their efforts in rendering expeditious service in those cases, which the rating boards desire complete examinations by our full time or part time specialists, including those which present a diagnostic problem, and those in which the diagnosis is in conflict with the military history or other evidence of record.

"It is desired that you submit a report to my personal attention on September 1, 1946, October 1, 1946, and November 1, 1946, as to the extent you have utilized the services of civilian physicians under the Ohio Plan, together with your comments concerning any problems that have arisen in making the plan effective."

FOUR IMPORTANT POINTS

It will be noted that Mr. Stone recommends to regional and sub-regional managers that:

1. They make use of the services of physicians in private practice to the fullest extent, "both in metropolitan and rural areas", in order to permit the use of clinical facilities of the Veterans Administration offices to clear up the backlog of pension rating examinations.

2. They take the "best interests of the veteran" into consideration when determining whether he shall be referred to a physician in private practice or to a Veterans Administration clinic for treatment.

3. They refer a "very large percentage" of service-connected cases to physicians of the veterans' choice "for continued treatment" after the intial claim has been adjudicated, to permit the regional and sub-regional medical facilities to be used for unusual or complicated examinations.

4. They submit reports on September 1, October 1, and November 1 as to the extent they have utilized the services of civilian physicians under the Ohio Plan, together with comments on problems which have arisen in making the plan effective.

PHYSICIANS WANT TO COOPERATE

As expressed in the letter to General Bradley, the medical profession of Ohio desires to cooperate 100 per cent with the Veterans Administration. It supports General Hawley in his efforts to give veterans with service-connected disabilities the best of medical care, believing that this can be accomplished if physicians in private practice are utilized to the fullest extent. Moreover, it believes that efficient medical services can be furnished more economically and with fewer delays and complications under the Ohio "home-town" doctor plan than through outpatient clinics of the Veterans Administration. Also, the Ohio State Medical Association has agreed to "police" its own ranks as a safeguard against abuses on the part of any member which would be detrimental to veterans and the government.

FATE OF PROGRAM HINGES ON SOLUTION

The Ohio Program is sound and easily administered. More than 4,000 Ohio physicians have indicated a willingness to participate. As already pointed out, it will function efficiently and successfully if sound and reasonable judgment is used by Veterans Administration officials charged with the responsibility of making authorizations and discharging other administrative duties, and if efforts are made by all participating physicians to conform to administrative regulations and to give veterans medical attention of the highest quality.

Fate of the Ohio Program hinges on solution of this administrative problem, making it feasible for physicians in private practice to assist the Veterans Administration as contemplated in the agreement effective last July 1.

Re: SULFAMERAZINE

(*sulfonamide of smaller dosage*) . . .

Efficiency in Treatment of Genito-Urinary Infections

Analysis of use of SULFAMERAZINE *in 151 patients:**

- ". . . efficient in relatively small doses and exerts its influence within a reasonably short time."*
- ". . . apparently shows no higher incidence of reactions than the other sulfonamides in comparable doses."*
- ". . . may frequently be given to patients who have reacted badly to one of the other sulfonamides with no further reaction, and it will often eliminate infections in patients who did not respond to the various other urinary antiseptics, including the other sulfonamides."*

A development of the Medical Research Division of Sharp & Dohme, Sulfamerazine is supplied in 0.5-Gm. tablets, for oral administration, in bottles of 100, 500 and 1,000; also in ¼-pound packages of powder. Sodium Sulfamerazine sterile powder, for intravenous administration, is supplied in 5-Gm. vials and in 50-cc. ampuls of a 6% solution. Sulfamerazine chemical reagent is supplied in 1-Gm. vials. Sharp & Dohme, Philadelphia 1, Pa.

SHARP & DOHME

*New Orleans Med. & Surg. Jl., 98:63-65, August 1945.

Actions of Congress on Medical-Health Proposals Reviewed: Possible Trends and Policies of the Future Analyzed

PROPOSED medical and health legislation held the spotlight up to the very end of the recent session of the 79th United States Congress, which forecasts even more heated battles between the pros and the cons on measures of this kind next January when the 80th Congress will convene.

During the closing hours of Congress the forces which have been crusading for federal medical programs of several varieties tried repeatedly to have their pet bills considered and rushed through during the hectic period which preceded adjournment.

The 79th Congress gave more consideration to measures which would extend the activities of the Federal Government into the field of health and medical care than previous Congresses. It did not enact any radical laws on these subjects although several of the measures passed are regarded by some as trends toward greater centralization of authority in Washington and toward expansion of social legislation of all types in the near future.

In general, the 79th Congress took a conservative path on most matters, indicating, according to some observers, that the policy of Congress for the visible future will be along conservative lines.

Nevertheless, certain patterns in social legislation were set. This is important to those interested in health and medical legislation as extensive future changes in social security would most certainly extend to the question of health services, medical care, etc.

PREDICTIONS ABOUT FUTURE

There is evidence, according to some commentators on the Washington scene, that Congress during the next few years will give more study than in the past to the broad subject of social security, including medical and health programs. This does not necessarily mean, they say, that Congress will go along with the suggestions of the ultra-liberal groups but that it will be more inclined to make gradual modifications and additions to the present social security program, setting up certain safeguards against excessive centralization and provisions for greater administrative authority on the part of the individual states.

The 79th Congress enacted several pieces of legislation which are regarded as important steps toward aiding the states and local communities in their efforts to improve medical and health services. These measures, with brief analyses of each, are as follows:

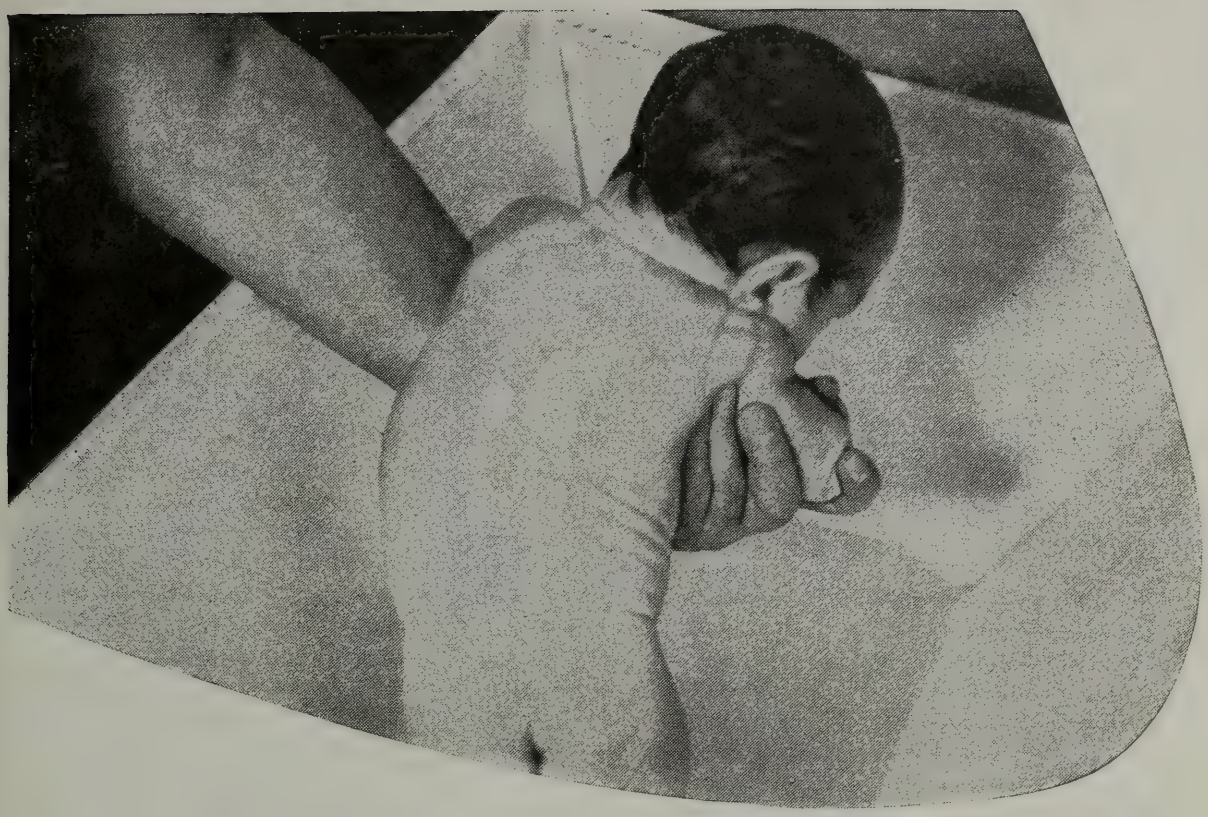
HOSPITAL BUILDING BILL

Hill-Burton Hospital Construction and Survey Bill: This measure, which was supported by many organizations, including national and local medical and hospital associations, makes possible the expenditure of $1,125,000,000 in the aggregate for a five-year hospital construction program. It authorizes $375,000,000 of Federal money to finance building and equipping activities and appropriates $3,000,000 to assist the states in making surveys, drafting plans, and designating where and what types of hospital facilities are necessary.

The bill authorizes the Federal Government to pay one-third of the costs of building or equipping new hospitals. Two-thirds of the costs must be contributed by sponsors of individual projects which may be private, non-profit hospital associations or corporations and state, county, and city governments. The money will be distributed to the states for use within the states on the basis of need for hospital facilities and in compliance with a per capita income formula. It establishes a national council to act in an advisory capacity and with the power to veto certain actions of the Surgeon General of the U. S. Public Health Service, the administrative officer of the program. Also, it provides that any eligible agency may appeal to the Federal courts if denied a grant under the new law.

It has been estimated that $37,000,000 will be available for hospital construction in Ohio when Federal funds have been appropriated and are available, and if the state, local political subdivisions, and private hospitals make 100 per cent contributions under the one-third, two-thirds matching arrangement. It is estimated that Federal funds available for Ohio annually for five years will amount to about two and one-half million dollars.

Congress still must appropriate the funds for the construction program. For this reason actual construction can not be started before next year. Also, as far as Ohio is concerned, a survey of hospital facilities must be made before Ohio can become eligible for Federal grants. Ohio will be eligible to receive a proportion of the $3,000,000 appropriated for surveys providing it makes available two-thirds of the amount needed for the Ohio survey. It is estimated that



First breath, first bath, first bottle

In a life filled with "firsts", baby has no time to cope with such gastro-intestinal problems as carbohydrate fermentation and attendant distention and diarrhea—particularly during his first few weeks.

'Dexin' has proven an excellent "first carbohydrate" because 1) its high dextrin content is not fermentable by the organisms usually present in the intestinal tract, and 2) because it promotes the formation of soft, flocculent, easily digested curds.

Simply prepared in hot or cold milk, 'Dexin' brand High Dextrin Carbohydrate is easily adapted to increasing formula needs from month to month, and later, being palatable but not too sweet, is a welcome supplement to other bland foods. 'Dexin' *does* make a difference.

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Composition—Dextrins 75% • Maltose 24% • Mineral Ash 0.25% • Moisture 0.75% • Available carbohydrate 99% • 115 calories per ounce • 6 level packed tablespoonfuls equal 1 ounce • Containers of twelve ounces and three pounds • Accepted by the Council on Foods and Nutrition, American Medical Association.

Literature on request

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the Ohio study will cost approximately $30,000.

The Ohio Legislature in special session on August 22 appropriated $15,655 for this purpose for the balance of 1946 and which is available for Federal matching.

SOCIAL SECURITY BENEFITS INCREASED

Increase in Social Security Benefits: Congress "froze" the payroll tax at 1 per cent each on employers' payrolls and employees' wages for Old Age and Survivors Insurance for another year but enacted legislation increasing Federal allowances to the states for pensions for the aged, services for crippled children and the blind, and for dependent children.

The so-called Pepper Bill to establish a National Maternal and Child Health Program—a little Wagner-Murray-Dingell Bill—remained in committee as the session ended. However, a mild compromise—mild in contrast to the radical provisions of the Pepper Bill—was worked out whereby the Children's Bureau will receive $22,000,000 or about double its customary appropriation, to be used for increased activities in the fields of maternal and child health and for increased allotments to the states on a matching basis. Expanded programs in most states may be anticipated as these additional funds are made available by the Federal Government.

CROSSER RAILROAD EMPLOYEES BILL

Railroad Workers Benefits Bill: Enactment of the Crosser Bill expanding the retirement and benefits program for railroad employees established what many believe will be the pattern for an expanded Social Security Program of the future covering all employed persons.

Under the Crosser measure railroad workers will receive greater retirement pay and his survivors larger benefits than the ordinary worker and his survivors receive under the Social Security Program. In addition to compensation while out of work, the railroad worker will receive benefits when unable to work because of sickness. Disability benefits are not now available to the ordinary worker under Social Security. The unemployment benefits allowed the railroad employee are greater than those which the ordinary worker receives. The Crosser Bill also provides cash maternity benefits for women employees of the railroads.

It has been estimated that the payroll tax which will be necessary to finance the Crosser Bill will amount to 9.25 per cent of employer payrolls and 6.25 per cent of the wages of employees, a total of 15.5 per cent. If the Social Security Program is expanded later, which some predict will happen, this tax is the figure which the expansion proponents are shooting for. It is said that the operation of the sickness benefits feature of the amended railroad retirement and benefits law will be watched with interest, with a view toward proposing insertion of a similar provision in the Social Security Law next year.

HEARINGS BUT NO ACTION

Miscellaneous Actions: Extensive hearings were held on the **Wagner-Murray-Dingell Bills** to provide for a system of compulsory sickness insurance. No action was taken by the committees hearing the testimony but considerable propaganda material was collected by the proponents of these measures for use in the Fall elections.

Brief hearings were held on the **Pepper Maternal and Child Health Bill** which would provide medical care at Federal expense for about half the population regardless of their economic status. No action was taken.

These bills are not dead, merely dormant. They could be called up at a special session of Congress this Fall which some predict the President will call if there is a change in the political complexion of Congress as a result of the Fall elections.

Bills to provide funds for **cancer research** failed to pass because of conflicting opinions as to what the terms of such a law should be.

A **National Mental Health Bill** was passed. It sets up machinery for research and for establishing clinics but Congress did not appropriate additional funds for the U. S. Public Health Service for this activity. It remains for the next Congress to take action on financing.

A proposal introduced by Senators Taft, Ball, and Smith to provide for Federal grants to the states for medical care for the needy and medically indigent **(see page 760 July issue, Ohio State Medical Journal)** remained in committee as the session ended. No hearings were given the measure.

Also, Senator Taft with Senator Fulbright introduced a proposal to create **a Department of Health, Education, and Security** to be administered by a Secretary appointed by the President. No action was taken on this bill.

Refresher Courses in Obstetrics

Bethesda Hospital, Cincinnati, has established a series of refresher courses in obstetrics for returned medical officers who would like an intensive review of this branch of medicine before resuming general practice.

The courses are for periods of two months each. They will be under the direction of instructors in the hospital's postgraduate gynecological and obstetrical resident training program, but will be restricted to obstetrics. No tuition fee is charged or any salary paid. Full maintenance will be provided by the hospital.

Further information can be obtained by writing A. N. McGinnis, superintendent, Bethesda Hospital, Oak Street and Reading Rd., Cincinnati 6.

SHOULD VITAMIN D BE GIVEN ONLY TO INFANTS?

VITAMIN D has been so successful in preventing rickets during infancy that there has been little emphasis on continuing its use after the second year.

But now a careful histologic study has been made which reveals a startlingly high incidence of rickets in children 2 to 14 years old. Follis, Jackson, Eliot, and Park* report that postmortem examination of 230 children of this age group showed the total prevalence of rickets to be 46.5%.

Rachitic changes were present as late as the fourteenth year, and the incidence was higher among children dying from acute disease than in those dying of chronic disease.

The authors conclude, "We doubt if slight degrees of rickets, such as we found in many of our children, interfere with health and development, but our studies as a whole afford reason to prolong administration of vitamin D to the age limit of our study, the fourteenth year, and especially indicate the necessity to suspect and to take the necessary measures to guard against rickets in sick children."

*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

MEAD'S Oleum Percomorphum With Other Fish-Liver Oils and Viosterol is a potent source of vitamins A and D, which is well taken by older children because it can be given in small dosage or capsule form. This ease of administration favors continued year-round use, including periods of illness.

MEAD'S Oleum Percomorphum furnishes 60,000 vitamin A units and 8,500 vitamin D units per gram. Supplied in 10- and 50-cc. bottles; also available in bottles of 50 and 250 capsules. Ethically marketed.

MEAD JOHNSON & COMPANY, Evansville 21, Ind., U.S.A.

SPECIAL MESSAGE TO ALL MEMBERS OF THE ASSOCIATION

VERY soon all Ohio physicians will receive a request from the Ohio Branch of the American Academy of Pediatrics that they furnish certain information to be used as a part of the Ohio Study of Child Health Services which is being conducted by this group of specialists.

It is the hope of the officers and members of The Council of the Ohio State Medical Association, who have officially approved this study, that each member of the Association will cooperate to the fullest extent. The information requested should be supplied on the blanks submitted—and promptly.

This is a sincere effort on the part of our own members and colleagues to gather accurate and unbiased information regarding medical and health services and facilities which are now available to children. It is part of a nation-wide study supervised by the American Academy of Pediatrics. It will reveal the strength or weakness of our present services and programs. It will provide the medical profession with important data to be used in future planning to meet proven needs; to be used, perhaps, in combatting misleading and exaggerated statements by those who are critical of existing programs.

Too many times the medical profession has sat back and let non-medical agencies and organizations take the initiative in such matters. It is time for a change. The study now under way is a step in the right direction as it is under professional guidance and is being conducted by those who have but one objective, namely, to get the facts and to make recommendations based on the facts—not on preconceived ideas and biased opinions.

For these reasons the Ohio study should have the support of all Ohio physicians and the information requested should be furnished by them without hesitation.

E. P. McNAMEE, M.D.
President

New Veterans Hospitals To Be Built at Cincinnati and Toledo

President Truman has approved plans for the acquisition of land for a number of Veterans Administration hospitals throughout the country, including two in Ohio.

Cincinnati will have a 750-bed general medical and surgical hospital on a 19½ acre tract adjoining the University of Cincinnati College of Medicine. Concurrently with the approval of the Cincinnati site, the President authorized the transfer of the Ft. Thomas, Ky., Army Post to the Veterans Administration, and the use of the present 200-bed Army hospital there as a nucleus for the construction of a 750-bed VA hospital for chronic medical and surgical cases. This settles, with a victory for both sides, the long contest between Cincinnati and Kentucky over the location of a hospital for veterans in that area.

The second VA hospital in Ohio, a 1,000-bed neuropsychiatric institution, will be located just outside the western limits of Toledo. The property covers 160 acres, with sufficient land for farming operations generally carried on by mental patients as part of their rehabilitation.

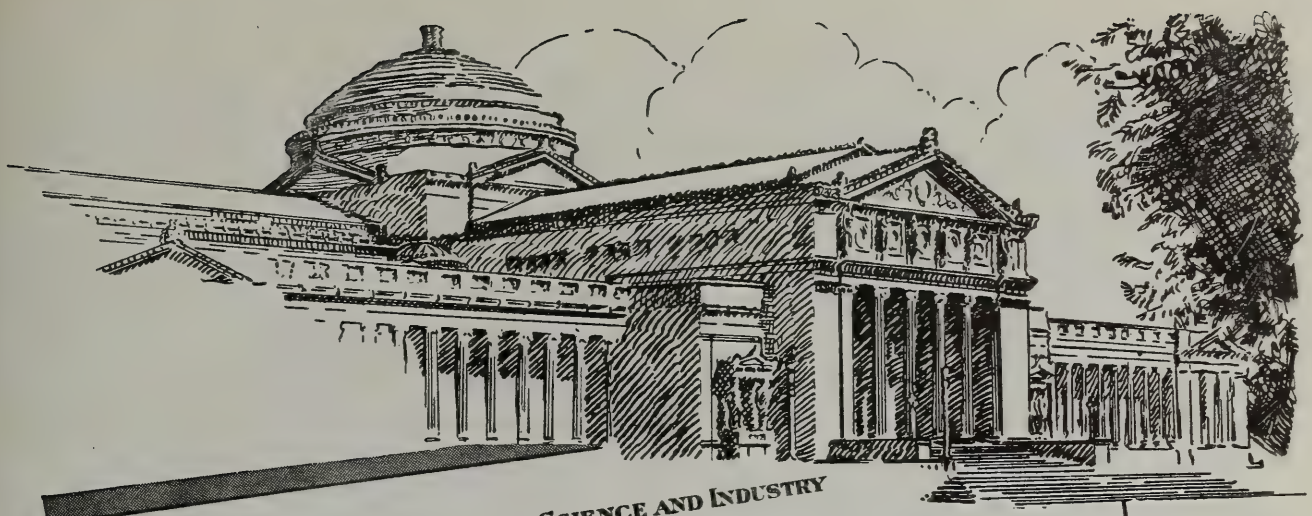
Industrial Health Congress in Boston, Sept. 30—Oct. 2

The seventh annual Congress on Industrial Health will be held at the Copley-Plaza Hotel in Boston, September 30 through October 2, 1946.

On Monday, September 30, the opening day, a clinical toxicological conference on lead poisoning is scheduled. During the afternoon a surgical conference on "The Foot in Industry" will be held, followed in the evening by a "Professional Relations Conference" and dinner.

The opening general session is scheduled on Tuesday morning, and the topic, "Human Relations in Iudustry" will be discussed. During the afternoon, elective seminars will be held on the following subjects: "Industrial Physiology", "Administrative Methods", and "Workmen's Compensation". A "Pan-American Industrial Health" dinner and conference will be held Tuesday evening.

General sessions are scheduled for Wednesday with the subject "Atomic Energy, Its Effects in Industry and Medicine" up for discussion in the morning, and "A Positive Health Program for Industry", in the afternoon. A dinner and conference on "Health and Welfare Programs in Industry" will close the conference Wednesday evening.



MUSEUM OF SCIENCE AND INDUSTRY
FOUNDED BY JULIUS ROSENWALD
JACKSON PARK · CHICAGO 37

August 7, 1946

Mr. C. H. Fleck, President
S. H. Camp and Company,
Jackson, Michigan

Dear Mr. Fleck:

Today marks the 10th Anniversary of the Transparent Woman exhibit and since the famous "lady" is making her permanent home in our Medical Section, we feel that the day should not be allowed to pass without some comment.

I vividly recall the premier of the Transparent Woman at Rockefeller Center in New York City before a distinguished assembly of physicians, scientists and educators. Its later tour throughout the Nation under the auspices of state and county medical societies and academies of medicine was a significant contribution to public health education. You are to be congratulated not only on your sponsorship of this important and effective exhibit but also on the ethical manner in which it was presented to the laity through the profession.

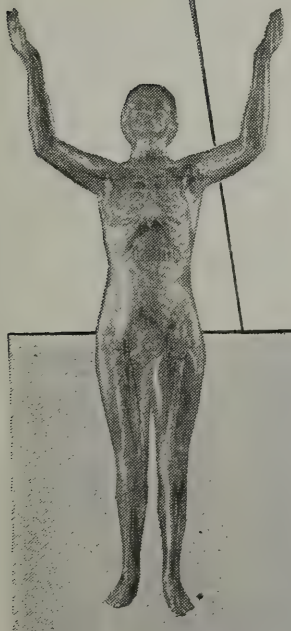
The Transparent Woman continues to be one of the major centers of interest at the museum. Practically all of the 1,026,250 visitors last year made her acquaintance and preliminary 1946 figures show the attendance running higher.

It is fitting on this 10th Anniversary of the Transparent Woman exhibit to again express our appreciation to you for your active interest in the Medical Section.

Cordially yours,

Eben J. Carey

EBEN J. CAREY, M.D., Curator,
Medical Exhibits



CAMP TRANSPARENT WOMAN EXHIBIT MARKS TENTH ANNIVERSARY

Dedicated at Rockefeller Center in 1936 by world famous figures in medicine, science and education, the *Transparent Woman* has since been viewed by some 50,000 physicians and 16,000,000 laymen. Its steady popularity in the Medical Section of the Museum of Science and Industry verifies our hope that the exhibit will continue to play its authentic role in public health education within the precepts of the medical profession.

S. H. CAMP and COMPANY · JACKSON, MICHIGAN

Ohio Medical Indemnity, Inc., Expands Into Toledo Area; Enrollment in Southwestern Ohio Shows Steady Growth

EXPANSION of the activities of Ohio Medical Indemnity, Inc., the prepaid medical expense plan being sponsored by the Ohio State Medical Association, into another area of Ohio has been announced by Mr. Charles H. Coghlan, executive vice president of the company.

Subscribers are now being enrolled in the 12-county area covered by the Hospital Service Association of Toledo (Blue Cross). An agreement has been established between Ohio Medical Indemnity, Inc., and the Toledo Hospital Service Association whereby the latter will perform certain administrative services in connection with the issuance and distribution of Ohio Medical Indemnity contracts in that territory.

NEW COUNTIES COVERED

Counties in which Ohio Medical Indemnity subscribers are now being enrolled under this expansion are: Lucas, Wood, Fulton, Henry, Williams, Defiance, Paulding, Ottawa, Sandusky, Seneca, Erie, and part of Huron.

The enrollment policy which has been in effect in the Cincinnati area, covering 14 counties, will be followed in the Toledo area. Subscribers will be enrolled only in groups and they will be, for the time being, holders of Blue Cross hospitalization contracts.

According to Mr. Coghlan the initiation of Ohio Medical Indemnity activities in the Toledo area was enthusiastically received by many employers and employees of the 12 counties. The headquarters of the Toledo Hospital Service Association has been besieged with telephone calls from employers and employees, inquiring about the plan and indicating an interest in immediate enrollment.

EXPANSION PLANNED

Negotiations are under way between officials of Ohio Medical Indemnity, Inc., and officials of several Blue Cross plans in other parts of the state for the expansion of Ohio Medical Indemnity enrollment in their territories. As soon as these have been completed, the company will expand its coverage into additional counties.

Mr. Coghlan reports that the business of the company in the Cincinnati area continues to show a steady growth. The plan was launched initially six months ago in the following 14 Southwestern Ohio counties: Hamilton, Clermont, Brown, Adams, Highland, Clinton, Warren, Butler, Preble, Montgomery, Greene, Clark, Miami, and Darke. Arrangements for administrative activities were worked out between Ohio Medical Indemnity and Hospital Care Corporation (Blue Cross) of Cincinnati.

As of September 1, approximately 40,000 persons in the Cincinnati area were eligible for participation in the benefits offered by Ohio Medical Indemnity, Inc., through the sale of individual and family contracts to groups of employees.

Tallman Named on National Mental Health Council

Dr. Frank F. Tallman, Ohio commissioner of mental hygiene, has been appointed by Dr. Thomas Parran, surgeon general of the United States Public Health Service, as one of six members of the National Advisory Mental Health Council, authorized by the National Mental Health Act, passed at the recent session of the U. S. Congress.



F. F. Tallman, M.D.

This council, which the act states shall consist of outstanding scientific and medical experts in the field of mental health, will be responsible for passing on all grants authorized by the act and will serve the Surgeon General in an advisory capacity on matters of policy.

Following are some of the features of the mental health act: Authorizes an appropriation for the building and equipping of a National Mental Health Institute to serve as a coordinating center for research in mental diseases; authorizes the U. S. Public Health Service to make grants and render other assistance to the states for the establishment of research units in the states; authorizes financial aid to states for the training of psychiatrists and the establishment of mental hygiene clinics.



For doctors' convenience-

VITAMIN D CONTENT OF FORMULAC INCREASED FROM 500 TO 800 U.S.P. UNITS

IN LINE with customary usage of vitamin D among pediatricians — and in response to requests from leading practitioners—the vitamin D content of FORMULAC Infant Food has been increased from 500 to 800 U.S.P. units.

FORMULAC originally had a vitamin D content of 500 units, more than adequate for the needs of *average* infants. At the request of pediatricians for added protection to cover even *exceptional* cases (such as prematures and others requiring larger amounts of vitamins in their diet) the vitamin D content has been raised 300 U.S.P. units.

For further information about FORMULAC, and for professional samples of this new vitamin-and-mineral fortified Infant Food, mail a card to National Dairy Products Company, Inc., 230 Park Avenue, New York 17, N. Y.

Distributed by **KRAFT FOODS COMPANY**

NATIONAL DAIRY PRODUCTS COMPANY, INC.

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ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

NATIONAL DAIRY Sealtest PRODUCTS CORP.

Digest of Ohio Prenatal Serologic Blood Test Law Which Places Important Responsibility on All Physicians

REPORTS from the Ohio Department of Health indicate that a considerable number of physicians appear to be unacquainted with the provisions of the Ohio Prenatal Serologic Blood Test Law.

Many of such physicians doubtlessly are those who were in military service at the time the law was enacted and who have recently resumed civilian practice.

Dr. Roger E. Heering, State Director of Health, has prepared a digest of the law for *The Journal* and it is published herewith for the information of all physicians, especially ex-servicemen.

Copies are being sent to all County Society Secretaries, with a request that the digest be read at a meeting of the society and members urged to comply with provisions of the law.

GOOD PUBLIC HEALTH MEASURE

This is a sound and constructive public health measure, meriting the active support and cooperation of all physicians.

The Ohio Prenatal Serologic Blood Test Law became effective August 22, 1945. The law provides:

"Every physician who attends any woman pregnant with child for conditions relating to pregnancy during the period of gestation shall take or cause to be taken a sample of blood of such woman at the time of first examination or within ten days thereof, and shall submit such sample to an approved laboratory for a standard serological test for syphilis. If, in the opinion of the physician attending such pregnant woman, the condition of such pregnant woman does not permit the taking of a blood sample for submission to an approved laboratory, then no sample shall be taken prior to delivery; however, if no sample is taken prior to delivery because of the pregnant woman's condition, then such blood sample shall be taken as soon after delivery as the physician deems it advisable."

When a pregnant woman is under the care of a person who is not authorized by law to take a sample of blood, an immediate report is to be made to the health commissioner whose duty it is to take, or cause to be taken, a sample of blood and to send the same to an approved laboratory.

LABORATORY REGULATION

The laboratories approved by the director of health for the purpose of making prenatal serologic blood tests are the same as those previously approved for making serologic blood tests for applicants for marriage license. **Prenatal blood samples are not to be sent to the laboratory of the State Department of Health except in cases where the physician can certify that the woman from whom the blood sample is taken is unable to pay for the test.** Report forms prescribed by the director of health are to be used by the approved laboratories in reporting the results of these blood tests and a duplicate copy of the report must be sent to the State Department of Health. The standard serologic tests for syphilis approved by the director of health are those approved by the United States Public Health Service; i.e., Eagle, Hinton, Kahn, Kline, Kolmer, and Mazzini.

In making a certificate of birth or stillbirth, the physician who was in attendance at the delivery is required to state whether a serologic test for syphilis was made and the approximate date of the test. In no event is the result of the test to be stated on the birth or stillbirth certificate.

The penalty for willful violation of this act is a fine of not more than one hundred dollars, with imprisonment for ten to thirty days, if fine and costs are not paid.

A copy of the prenatal act will be sent by the State Director of Health on request.

Ohio Physicians Elected

The following Ohio physicians were elected officers of sections at the recent San Francisco session of the American Medical Association: Dr. Joseph T. Wearn, Cleveland, chairman and member of executive committee, Section on Internal Medicine; Dr. Marion A. Blankenhorn, Cincinnati, member of executive committee, Section on Internal Medicine; Dr. Louis Karnosh, Cleveland, vice chairman, Section on Nervous and Mental Diseases; Dr. Paul A. Davis, Akron, chairman, and Dr. J. Craig Bowman, Upper Sandusky, member of executive committee, Section on General Practice of Medicine.

Clinical Congress To Cleveland

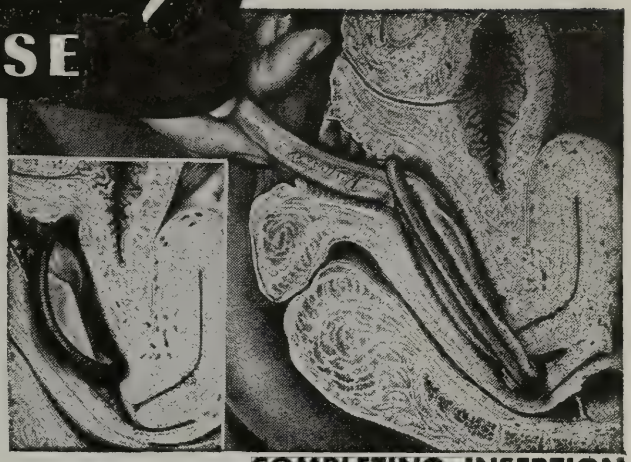
The annual clinical congress of the American College of Surgeons will be held in the Cleveland Public Auditorium, Dec. 16-20, instead of in New York, Sept. 9-13. The transfer was made because of a shortage in hotel accommodations in New York during September, when the United Nations Assembly is scheduled to meet.

Chillicothe—The Mead Corporation has named Dr. Walter C. Breth as medical director for its paper manufacturing plants in eight states.

Simplicity IN USE

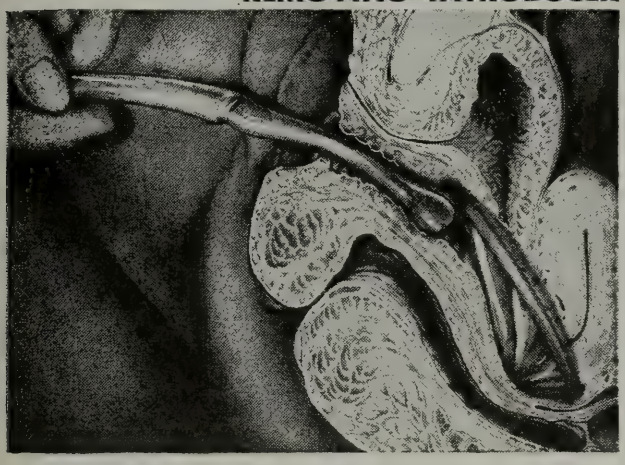


BEGINNING INSERTION



COMPLETING INSERTION

REMOVING INTRODUCER



SEATING DIAPHRAGM



These illustrations, showing the simplicity of use of "RAMSES" Gynecological Products, are reproduced from the booklet *Instructions for Patients*. For the physician's convenience, a supply of these booklets is available, upon request, for distribution to patients.

Determination of indications for control of conception, and advice on the proper method of providing protection, are the exclusive province of the physician. "RAMSES"* Gynecological Products are designed for use under the guidance of the physician only.

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Interesting Data on Births and Deaths in Ohio Included In Division of Vital Statistics Report for 1945

PRESENT trends indicate that Ohio will have a decided increase in births for 1946 over last year, according to William H. Veigel, chief of the Division of Vital Statistics of the Ohio Department of Health.

Births in Ohio set an all-time record high during the month of July, 1946, and previous months' totals also show an increase over 1945 figures. Veigel commented that the increase is probably due in a large part to the end of the war and the establishment of families by returning servicemen.

These observations accompanied the release of the 1945 *Annual Vital Statistics Report by Residence and Place of Occurrence,* published by the division.

TEN LEADING CAUSES OF DEATH

Significant items in the report itself include the listing of the ten leading causes of death for 1945, in order of their importance, as follows: Heart disease, cancer, cerebral hemorrhage, nephritis, pneumonia, tuberculosis, diabetes, premature birth, accidental injuries from falls, and auto accidents.

The above ten items made up 76 per cent of the total deaths, and the other 24 per cent was spread over 190 other listed causes.

Deaths from all causes in Ohio last year totaled 77,625, or a rate of about 11.0 per 1,000 population, a slight decline from the 79,868 deaths in 1944, a rate of 11.4.

Diseases of the heart, leading cause of death, slightly decreased with a toll of 24,347 in 1945 as compared with a figure of 24,409 for the previous year, a reduction from about 349 deaths per 100,000 population to 345.

CANCER DEATHS INCREASE

Cancer deaths in Ohio increased from 9,953, a rate of 141.7 per 100,000 residents in 1944, to 10,168, or a rate of 144.28 per 100,000 in 1945. According to Veigel, this follows a trend of several years.

Tuberculosis deaths decreased from 2,755 in 1944 to 2,573 in 1945, but this disease is still the leading cause of death in the age bracket 15 through 35.

Deaths from influenza decreased in 1945 to a total of 575, from the pervious year's 1,171.

MATERNAL AND INFANT DEATHS DECLINE

The report showed a continued decline in maternity deaths and deaths of infants under one year of age, puerperal deaths totaling 225 in 1945 as against 252 for the previous year, and infant deaths numbering 4,717 as compared with 5,136 in 1944.

The rate of maternity deaths in 1945 was 17.05 per 10,000 live births, as compared with a rate of 68.38 in 1910. This rate climbed as high as 93.96 in 1918, before it began a fairly consistent drop to present day figures. Infant mortality rates have dropped from a rate of 113 per 1,000 births in 1910, to the 1945 rate of 36. The highest rate, 122 per 1,000, occurred in 1913.

POLIO LIGHT IN 1945

Infantile paralysis deaths dropped to 29 in 1945 after the 1944 epidemic year's total of 88.

Rural residents had a death rate of 10 persons per 1,000 population in 1945, as against a rate of 11.6 for urban dwellers. Huron County had the highest death rate, 14.4 per 1,000, and Paulding the lowest, with 6.4 per 1,000 residents.

BIRTH RATE DOWN LAST YEAR

Births in Ohio decreased from 132,531, a rate of 18.9 per 1,000 population in 1944, to 131,910 in 1945, which is a rate of about 18.7.

Birth rates were generally lowest in Southeastern and Southern Ohio, with the higher rates occurring in Northeast and West Central portions. Greene County had the highest rate with 25.4 births per 1,000 and the lowest, Noble, with 8.8 per 1,000.

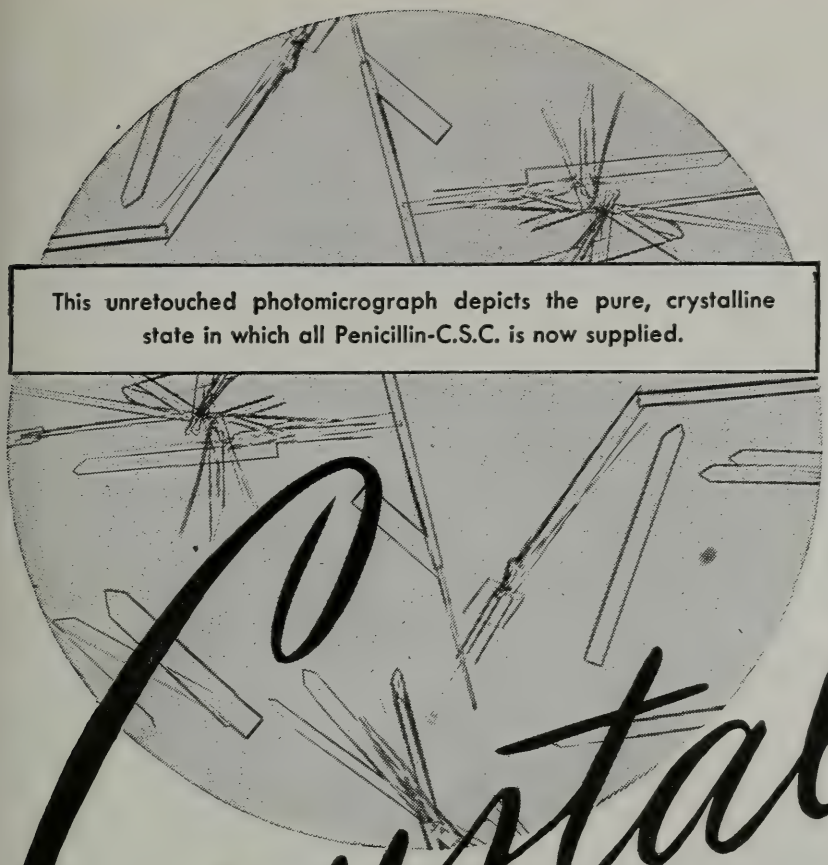
HOSPITAL BIRTHS REACH 87 PER CENT

Following a definite trend over a number of years, the number and percentage of births occurring in hospitals reached a total of 115,381 in 1945, or 87.46 per cent of all births. Percentages during preceding years were 76.4 in 1942, 77 in 1943, and 84 in 1944.

Illegitimate births increased from 3,714 in 1944 to 4,262 in 1945.

Legal Medicine Seminar

Announcement is made of a Seminar in Legal Medicine sponsored jointly by the Department of Legal Medicine, Harvard Medical School, and the Massachusetts Medico-Legal Society, and given in cooperation with the Medical Schools of Boston University and Tufts College, covering the entire week of October 7-12. The seminar will cover subjects of particular interest to medical examiners, coroners, pathologists and others particularly interested in medico-legal investigations. Attendance is limited to twenty. For further information write to Dr. William H. Watters, Harvard Medical School, 25 Shattuck Street, Boston, Mass.



This unretouched photomicrograph depicts the pure, crystalline state in which all Penicillin-C.S.C. is now supplied.

SYMBOL OF PURITY

Crystalline PENICILLIN SODIUM-C.S.C.

As a result of special processes of purification and crystallization, all Penicillin-C.S.C. is now supplied in the form of the highly purified, heat-stable Crystalline Sodium Salt of Penicillin-C.S.C.

Well Tolerated Subcutaneously

In the crystalline state Penicillin Sodium-C.S.C. is so pure that it can be administered subcutaneously even in large doses with virtually no pain or danger of untoward reactions due to impurities.

No Refrigeration Required

Crystalline Penicillin Sodium-C.S.C. is so heat-stable that it can be kept at room temperatures, virtually indefinitely without losing its potency.* It can now be carried in the physician's bag or stored on the pharmacy shelf. No longer need the physician wait until the patient can be hospitalized or until refrigerated penicillin can be obtained from the nearest depot.

*CAUTION: Once in solution, however, penicillin still requires refrigeration.

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Because of its high potency per milligram, Crystalline Penicillin Sodium-C.S.C. exerts optimal therapeutic activity. A recent report shows the advantage of highly potent preparations.[1]

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The high state of purification achieved in Crystalline Penicillin Sodium-C.S.C. is indicated by *its high potency per milligram*. The number of units per milligram is stated on each vial, thus enabling the physician to know the degree of purification of the penicillin he is using.

[1] "The potency of the penicillin undoubtedly affected the results. The first 15 patients, all treated with the same batch of penicillin, were cured. The next 7 patients were treated with the same dosage of a different batch of penicillin. Five of these 7 were not cured. Assays of penicillin used for these 7 patients showed it to be of reduced potency." Trumper, M., and Thompson, G. J.: Prolonging the Effects of Penicillin by Chilling, J.A.M.A. *130*: 628 (March 9) 1946.



Crystalline Penicillin Sodium-C.S.C. is available in serum-type vials containing 100,000, 200,000, or 500,000 units.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

Penicillin-C.S.C. is accepted by the Council on Pharmacy and Chemistry of the American Medical Association

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RETURN TO CIVILIAN LIFE AFTER MILITARY SERVICE

FOLLOWING are the names of additional Ohio physicians who have been released from military service or have started terminal leave, according to information received recently by *The Journal*. The rank shown is based on the most recent data in the files of the Ohio State Medical Association:

Name	City	Rank
Arnold, Emmet W.	Columbus	Capt., A.U.S.
Bannister, William K.	Lima	Lt. Comdr., U.S.N.R.
Barnes, Nolan T.	Toledo	Lt. Comdr., U.S.N.R.
Battles, Morris L.	N.Y., N.Y. (formerly of Chesterland)	Major A.U.S.
Besserglick, Irving	Cleveland	1st Lt., A.U.S.
Bishko, Maurice J.	Cleveland	Major, A.U.S.
Blackledge, Ord C.	Cleveland	Lt. Col., A.U.S.
Block, Gordon L., Jr.	Cincinnati	Capt., A.U.S.
Bonser, William H.	Toledo	Major, A.U.S.
Booth, George T.	Toledo	Major, A.U.S.
Brown, Harold E.	Columbus	Capt., A.U.S.
Burkhart, S. E.	Cleveland	Lt., U.S.N.R.
Burt, Olan P.	Columbus	Capt., A.U.S.
Clark, Ivan T.	Duluth, Minnesota (formerly of Columbus)	Capt., A.U.S.
Clark, William P.	Cincinnati	Capt., A.U.S.
Cohen, Lewis	Columbus	Capt., A.U.S.
Consolo, Charles W.	Tiffin	Major, A.U.S.
Crile, George, Jr.	Cleveland	Comdr., U.S.N.R.
DeBold, John A.	Steubenville	Capt., A.U.S.
DeMarco, R. A.	Elyria (formerly of Cleveland)	Major, A.U.S.
Devins, Edward J.	Cincinnati	Major, A.U.S.
Dillahunt, Paul H.	Columbus	Capt., A.U.S.
Dillon, Lowell O.	Lima	Major, A.U.S.
Durschlag, S. W.	Cleveland	1st Lt., A.U.S.
Fisher, Alexander S.	East Liverpool	Capt., A.U.S.
Foertmeyer, Charles H.	Cincinnati	Capt., A.U.S.
Foley, James M.	Columbus	Capt., A.U.S.
Frame, Victor A.	New Richmond (formerly of Cincinnati)	Capt., A.U.S.
Franzblau, Abraham N.	Cincinnati	P.A.S., U.S.P.H.S.
Freeman, Marvin S.	Cleveland	1st Lt., A.U.S.
Frommeyer, Walter B., Jr.	Cincinnati	Capt., A.U.S.
Garrett, Wm. M.	Frankfort	Capt., A.U.S.
Glicklich, Earl A.	Boston, Massachusetts (formerly of Cincinnati)	Lt. Col., A.U.S.
Goldberg, Lawrence C.	Cincinnati	Major, A.U.S.
Goodman, Seaburt	Cleveland	1st Lt., A.U.S.
Hackleman, Gene L.	Springfield	Lt. (jg.) U.S.N.R.
Hargett, Herbert	Springfield	1st Lt., A.U.S.
Heller, Morris I.	Cleveland	Capt., A.U.S.
Helmbold, August F. W.	Cincinnati	Major, A.U.S.
Hendricks, Anthony B.	Cincinnati	Major, A.U.S.
Heringhaus, Francis J.	Mansfield	Lt. Col., A.U.S.
Hochwalt, Jerome P.	Lebanon	Capt., A.U.S.
Hoerner, M. T.	Dayton	Major, A.U.S.
Hoffman, Edward O.	Cincinnati	Major, A.U.S.
Humphries, William C.	Cleveland	Capt., A.U.S.
Johnson, Bernard L.	Deshler	Lt. Comdr., U.S.N.R.
Kalina, Roger K.	Cleveland	Lt. Col., A.U.S.
Kennedy, Kendall O.	Utica (formerly of Delaware)	1st Lt., A.U.S.
Kilpatrick, Elmer M.	Lebanon (formerly of Columbus)	Major, A.U.S.
Kirk, Thomas M.	La Jolla, California (formerly of Dayton)	Col., A.U.S.
Kogut, Lewis V.	Cleveland	Capt., A.U.S.
Kostoff, Albert	Columbus	Capt., A.U.S.
Kronenberg, Sanford	Cleveland	Capt., A.U.S.
Krupko, Paul E.	McDonald	Capt., A.U.S.
Ladd, L. W.	Cleveland	Capt., A.U.S.
Lamkin, Glenn S.	Sardinia	Major, A.U.S.
Leary, William G.	San Francisco, California (formerly of Cincinnati)	Lt., U.S.N.R.
LeFever, Harry E.	Columbus	Lt. Comdr., U.S.N.R.
LeFevre, John D.	Springfield	Capt., A.U.S.
Lehmann, Benjamin J.	Hamilton	Major, A.U.S.
Levin, Tom S.	Cincinnati	Lt. Comdr., U.S.N.R.
Light, Wilbur B.	Lima	Major, A.U.S.
Lynch, James	Cleveland	Lt. Comdr., U.S.N.R.
Maggied, Sol	West Jefferson (formerly of Columbus)	Lt., U.S.N.R.
Marinis, Thomas P.	Mansfield	Capt., A.U.S.
Marks, Matthew O.	Cleveland (formerly of Youngstown)	1st Lt., A.U.S.
Marshall, Edward A.	Cleveland	Major, A.U.S.
Martin, Morris B.	Springfield	Capt., A.U.S.
Martin, Norvil A.	Gallipolis	Lt. Col., A.U.S.
McGavran, Charles W.	Columbus	Capt., A.U.S.
McNamee, Regis J.	Lakewood	Major, A.U.S.
Meyer, William G.	Columbus	Major, A.U.S.
Minnig, Donald I.	Akron	Lt. Col., A.U.S.
Montanus, William P.	Springfield	Capt., A.U.S.
Musta, Walter	Cleveland	Major, A.U.S.
Neiswander, Paul L.	Akron	Capt. A.U.S.
Nichols, John H.	Cleveland	Comdr., U.S.N.R.
Page, Robert O.	Lima	Major, A.U.S.
Parker, Lester	Cleveland	Lt. (jg.) U.S.N.R.
Perlman, Robert	Cincinnati	Lt. Col., A.U.S.
Pierce, Robert R.	Cincinnati	Capt., A.U.S.
Pischieri, J. V.	Cleveland	Capt., A.U.S.
Rea, Frederick W.	Marion	Lt., U.S.N.R.
Rector, Lewis E.	Akron	Lt., U.S.N.R.
Riemenschneider, Edwin A.	Akron (formerly of Cleveland)	Lt., U.S.N.R.
Ringer, Robert A.	Cambridge	Capt., A.U.S.
Roettig, Louis C.	Columbus	Major, A.U.S.
Rogoff, Robert	Cleveland	1st Lt., A.U.S.
Rudolph, Jack A.	Miami Beach, Florida (formerly of Columbus)	Major, A.U.S.
Ryan, Edward J.	Cleveland	Lt. Comdr., U.S.N.R.
Sacheroff, Louis	Lakewood	Capt., A.U.S.
Sargis, Harold T.	Cleveland	Lt. (jg.) U.S.N.R.
Sawan, Edward A.	Akron	Lt. Col., A.U.S.
Schwartz, Edward D.	Cleveland	Major, A.U.S.
Searle, Clark P.	Wyoming	Capt., A.U.S.
Selman, Morris W.	Toledo	Major, A.U.S.
Shaper, Aaron A.	Louisville, Kentucky (formerly of Cincinnati)	Comdr., U.S.N.R.
Shecket, Harman A.	Cleveland	1st Lt., A.U.S.
Shimansky, L. E.	Vermillion	Major, A.U.S.
Simiele, Victor A.	Lancaster	Lt. Comdr., U.S.N.R.
Smarrella, John P.	Steubenville	Capt., A.U.S.
Snyder, Warren G.	Steubenville	Capt., A.U.S.
Speck, Myron E.	Cleveland	Major, A.U.S.
Stewart, Dudley M.	New Orleans, Louisiana (formerly of Toledo)	Major, A.U.S.
Stonehill, Theodore	Los Angeles, California (formerly of Cleveland)	Capt., A.U.S.
Tapper, Ralph W.	Dayton	Capt., A.U.S.
Tepe, William R.	Norwood	Capt., A.U.S.
Terrell, Virgil E.	Cleveland	Capt., A.U.S.
Tetalman, Sam	Cleveland	Capt., A.U.S.
Thomasson, Leslie H.	Cleveland	Lt. (jg.), U.S.N.R.
Tillman, Norbert A.	Lorain	Col., A.U.S.
Totterdale, William G.	Warren	Comdr., U.S.N.R.
Updegraff, Ralph K.	Bellefontaine (formerly of Cleveland)	Major, A.U.S.
Wallace, Ervin B.	Columbus	Capt., A.U.S.
Weckesser, Elden C.	Cleveland	Lt. Col., A.U.S.
Weems, Philip D.	Portsmouth	Lt. Comdr., U.S.N.R.
Weiss, Andrew J.	Cincinnati	Lt. Comdr., U.S.N.R.
Wells, William M.	Columbus	Capt., A.U.S.
Werner, Marshall R.	Akron	Major, A.U.S.
Winston, Samuel H.	Dover	Capt. A.U.S.
Wirtschafter, Zolton T.	Beverly Hills, Calif. (formerly of Cleveland)	Lt. Col., A.U.S.
Yeager, Floyd D.	Marion	Major, A.U.S.

Military Surgeons Meeting

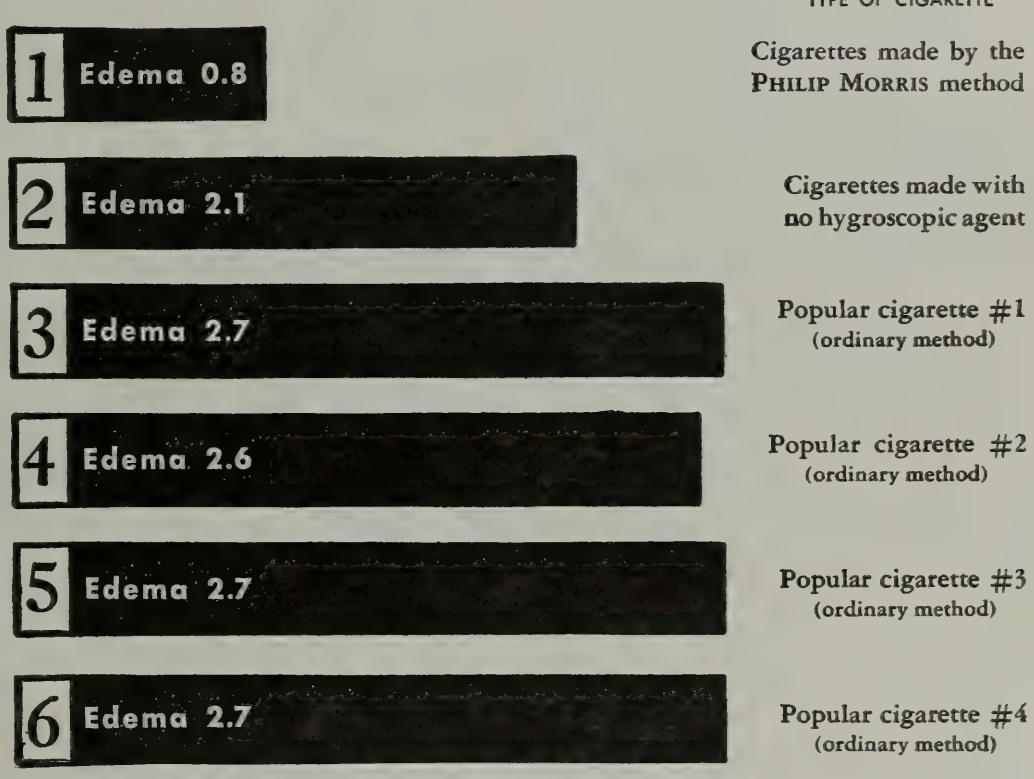
The Association of Military Surgeons of the United States will meet at the Hotel Book-Cadillac, Detroit, Oct. 9-11. The program will include addresses, symposia, and panel discussions. Requests for hotel reservations should be addressed to Dr. Burt R. Shurly, chairman, Hotels Committee, 1005 Stroh Bldg., Detroit 26.

Newell Heads Veterans' Group

Dr. T. E. Newell, Dayton, is the new president of the Montgomery County Veteran Doctors' Association, formed to assist veteran physicians in their return to private practice. Other officers are: Dr. Frederick Miller, vice-president; Dr. Richard T. Sauer, secretary; Dr. William Gitman, treasurer; and Dr. John Torrence, sergeant-at-arms.

How irritation varies from *different* cigarettes

Tests made on rabbits' eyes reveal the influence of hygroscopic agents*



CONCLUSION:* Results show that regardless of blend of tobacco, flavoring materials, or method of manufacture, the irritation produced by all ordinary cigarettes is substantially the same, and measurably greater than that caused by PHILIP MORRIS.

CLINICAL CONFIRMATION: ** When *smokers* changed to PHILIP MORRIS, substantially every case of irritation of the nose and throat due to smoking cleared completely or definitely improved.

**N. Y. State Journ. Med. 35 No. 11,590* ***Laryngoscope 1935, XLV, No. 2, 149-154*

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

VETERANS' INQUIRY DEPARTMENT

Ohio Openings and Locations Sought by Returning Medical Officers; Opportunities Available Listed

THE purpose of this department is to provide space without cost to Ohio veteran physicians for the publication of inquiries they may wish to make concerning an assistantship or residency, a partnership or space in an office, locations and purchase of a practice, purchase of equipment, etc.

The new feature also offers an opportunity for physicians who desire to dispose of their practice or institutions and agencies needing staff physicians to publicize this information for the benefit of service men.

The feature will appear monthly as long as there seems to be a need for it. The regulations governing it are: (1) The veteran submitting the inquiry must be an Ohio physician, i.e., one who was in practice in Ohio when he entered the service or was a native of Ohio but still in training when he entered in the service. (2) Inquiries should not exceed 35 words. (3) Copy must be submitted by the 20th day of the month preceding date of publication. (4) Unless otherwise specified, each inquiry will be carried in two consecutive issues of *The Journal* but no oftener. (5) *The Journal* reserves the right to reject or edit copy submitted; also, to eliminate the new department when and if conditions warrant. (6) Inquiries should be accompanied by full name, forwarding address and identifying data.

OPPORTUNITIES SOUGHT

LOCUM TENENS DESIRED: Wanted for three months beginning September 15 by Navy medical officer who will begin residency January 1. Graduate of Harvard Medical School in 1944; aged 26; internship Lakeside Hospital, Cleveland. V.I.D. No. 22.

SEEKS INDUSTRIAL ARRANGEMENT: Veteran with extensive industrial background seeks association with individual or group in this type of practice. Willing to invest. Cleveland area preferred but others also considered. V. I. D. No. 23, care of Ohio State Medical Journal.

ASSISTANTSHIP WANTED: Assistantship to general practitioner or radiologist sought by naval officer to be discharged September 1. Age 28. Ohio license. Graduate of Cincinnati University College of Medicine. Rotating internship. Two and one-half years part-time civilian and two years Navy roentgenology. V.I.D. No. 24.

ASSISTANTSHIP WANTED: Navy veteran desires assistantship with busy general practitioner or obstetrician. Graduate of University of Louisville School of Medicine, 1944; rotating internship. Aged 24; single. V.I.D. No. 25.

ASSOCIATION DESIRED: Veteran desires position with small medical group or assistantship with pediatrician or general practitioner in town over 20,000. Ultimate desire is to specialize in pediatrics. V.I.D. No. 26.

ASSISTANTSHIP WANTED: Surgeon, aged 32, Army experience and eligible to American Board of Surgery, available in Fall of 1946, desires assistantship to older surgeon, group practice, association with internist, etc. Experience in general surgery, neurosurgery, orthopedic surgery; Ohio license. V.I.D. No. 27.

ASSISTANTSHIP SOUGHT: Discharged Army medical officer, aged 30, desires assistantship with established general practitioner. Graduate of Ohio State University in 1942; one year rotating internship City Hospital, Nashville, Tenn. Married, one child. V.I.D. No. 28.

WANTS ASSOCIATION WITH GROUP OR SPECIALIST: Army veteran, aged 31, married. Ohio State University graduate, Ohio license, eligible to American boards in obstetrics and gynecology, desires position with group clinic or established specialist. Spent 21 months in ETO in general surgery and ob-gyn. V.I.D. No. 29.

SEEKING ASSISTANTSHIP: Army veteran desires assistantship with general practitioner, with possible future partnership. Ohio State University graduate in 1943; rotating internship; aged 30; single. V.I.D. No. 30.

ASSOCIATESHIP, GROUP OR SPECIALIST SOUGHT: Veteran with qualifications for certification by American Board of Internal Medicine, aged 30, graduate of Ohio State University, desires association with group or with board member—preferably with university affiliations. Have had research and teaching experience. V.I.D. No. 31.

OPPORTUNITIES OFFERED

ASSOCIATION WITH SURGEONS: Opening for young man, not interested in surgery, who would like to be associated in practice with two well-established surgeons. Compensation on percentage of gross income to the practice, depending upon training and personal qualifications. Part-time residence could be obtained in a small general hospital at substantial salary while a practice is being built. Industrial town of 15,000 population, Northeastern Ohio. All equipment and supplies furnished. Write H.R.A., care of Ohio State Medical Journal.

OPENING FOR ANESTHETIST: Diplomate of Board of Anesthesiology or fellow of American Society of Anesthesiology wanted as an associate or to practice independently as a full-time anesthetist. Write Fred W. Brosius, M.D., Middletown, Ohio.

PRACTICE AVAILABLE: General practice in DeGraff available. No property to sell. Forced to retire because of health. Good field for lively young physician. Write O. W. Loffer, M.D., DeGraff.

INTERNS AND HOUSEMEN NEEDED: Good Samaritan Hospital, Dayton, has openings for six interns. Internships approved by American Medical Association. Weekly seminars offered by members of various specialty boards. Also vacancies for four returning veterans as housemen; also entitled to seminars. Stipends for interns $50.00 with full maintenance; stipends for housemen, $150.00 with full maintenance. Contact Intern Committee of hospital.

PRIVATE INDUSTRIAL PRACTICE: Good opportunity for young physician who wishes to engage in private industrial practice in industrial center. Physician now handling work changing locations. If interested, write T.H.L. care of Ohio State Medical Journal.

CLINIC STAFF OPENING: Opening for young man interested in general practice on staff of group clinic. Compensation first few months on salary basis; thereafter on percentage basis. All equipment furnished by clinic. L.A.C. care of Ohio State Medical Journal.

PART-TIME INDUSTRIAL PRACTICE: Good opening for physician interested in part-time industrial practice, physical examinations, and emergencies. Columbus industrial firm. Write C.W.C., care of the Ohio State Medical Journal.

(Continued on page 982)

ESTROGENIC SUPPORT WHEN NEEDED MOST



This well tolerated synthetic estrogen offers all of the advantages of the natural substances, and at the same time is far more economical. It is not a stilbene derivative.

Clinicians who have investigated Schieffelin BENZESTROL agree that the response of patients suffering from the distressing symptoms that frequently attend the menopause, has been most gratifying.

In addition, Schieffelin BENZESTROL has proved of benefit for the suppression of undesirable lactation and as a supplementary medication in infantile gonorrheal vaginitis.

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Available in tablets of 0.5, 1.0, 2.0 and 5.0 mg.; in solution in 10 cc. vials, 5 mg. per cc.; and vaginal tablets of 0.5 mg. strength.
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INTERNATIONAL SURGICAL ASSEMBLY

UNITED STATES CHAPTER, INTERNATIONAL COLLEGE OF SURGEONS

MASONIC TEMPLE, DETROIT, OCTOBER 21, 22, 23, 1946

President, Herbert Acuff, Knoxville, Tenn. President-Elect Custis Lee Hall, Washington, D. C., Secretary and Chairman Detroit Assembly, L. J. Gariepy, 16401 Grand River Avenue, Detroit 27

ALL MEDICAL MEN AND WOMEN IN GOOD STANDING CORDIALLY INVITED

Intensive Clinical and Didactic Program by World Authorities

Operative Surgical Clinics, Monday morning, October 21 in seventeen Detroit hospitals

Convocation Speakers: Former Ambassador to Japan Joseph C. Grew. Congressman George A. Dondero from Mich.

Banquet Speakers: Admiral Chester W. Nimitz, Vice Admiral Ross T. McIntire, Morris Fishbein, M.D.

The following is list of members of the profession who will take part in program:

Lyon H. Appleby, Vancouver, B. C.
Hamilton Bailey, London, Eng.
W. Wayne Babcock, Philadelphia
Harry E. Bacon, Philadelphia
Channing W. Barrett, Chicago
Moses Behrend, Philadelphia
A. A. Berg, New York
Gerald L. Burke, Vancouver, B.C.
Sebastian J. Carnazzo, Omaha, Neb.
Felipe Carranza, Buenos Aires, Argentina
Alejandro Ceballos, Buenos Aires, Argentina
David deSanson, Rio de Janeiro, Brazil
Francisco Grana, Lima, Peru
J. P. Greenhill, Chicago, Ill.
E. S. Gurdjian, Detroit
Custis Lee Hall, Washington, D.C.
Stuart W. Harrington, Rochester, Minn.
Rudolph Jaeger, Philadelphia
Albert Jirasek, Prague, Czechoslovakia
Charles G. Johnston, Detroit
Wm. E. Johnston, Detroit
Herbert I. Kallet, Detroit
Roland M. Klemme, St. Louis
Lloyd G. Lewis, Baltimore
Wm. C. MacCarty, Rochester, Minn.
Lowrain E. McCrea, Philadelphia
Raymond W. McNealy, Chicago
Karl A. Meyer, Chicago
J. H. Mulholland, New York
Rudolf Nissen, New York
Richard H. Overholt, Brookline, Mass.
Col. John F. Pick, Chicago, Ill.
Carl A. Rosenbaum, Little Rock, Ark.
Max Thorek, Chicago, Ill.
Harold C. Voris, Chicago, Ill.
Robertson Ward, San Francisco
James M. Winfield, Detroit
Otis R. Wolfe, Marshalltown, Iowa
Edwin L. Zander, New Orleans

Hotel Headquarters: Book-Cadillac Hotel and Statler Hotel. FOR HOTEL RESERVATIONS write C. W. Husband, Chairman, Housing Committee, 1005 Stroh Bldg., Detroit 26, Mich.

Any doctor of medicine who uses surgery in his practice will find this meeting of great value.
A program will be mailed to every member of the medical profession in good standing in the United States and Canada, upon request to the Secretary, about October 1.

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LOCATION FOR GENERAL PRACTICE: Opening for general practice in town of 3,500 on Ohio River. Office space available. Shortage of active physicians at present. Box S, care of Ohio State Medical Journal.

INDUSTRIAL COMMISSION: Openings available in Medical Section, Ohio Industrial Commission. Consult Dr. Robert André, chief supervisor, Medical Section, State Office Bldg., Columbus.

STATE HOSPITAL STAFF OPENINGS: Staff physicians for various institutions serving the mentally ill, mentally defective and epileptic needed. Physicians who have had some psychiatric training or experience preferred but can offer positions to doctors who may be interested in becoming acquainted with the specialty. A position of special importance now open is: Clinical Directorship, Gallipolis State Institute (fine opportunity for man who has had neuropsychiatric training to become acquainted with those neurological conditions that cause epilepsy in addition to a chance to be a specialist in the field of true epilepsy). Consult Dr. Frank F. Tallman, Ohio Commissioner of Mental Hygiene, State Departments Building, Columbus 15.

PUBLIC HEALTH OFFICERS NEEDED: Several counties in Ohio in need of full-time health commissioners. Those with training and experience, or interested in public health work, may obtain complete details from Dr. Roger Heering, Ohio Director of Health, State Departments Building, Columbus 15.

PRACTICE FOR SALE: Active practice in a community of 3,000, North Central Ohio. Large amount of industrial work in addition to regular practice. Equipment includes new X-ray, diathermy, modern furniture, drugs and supplies. No real estate for sale. Moderate rent. Estimated price $7,500, cash or terms. Will introduce for a short time. Write R.J.S., care of Ohio State Medical Journal.

VETERANS ADMINISTRATION: Openings for physicians as members of rating boards for either full time or part time duty. Basic salary $4300.00 per annum, with additional compensation for overtime. Contact nearest V.A. office for particulars.

FULL-TIME RESIDENT PHYSICIAN NEEDED: At Homeplace, Perry County, Kentucky, operated by E. O. Robinson Mountain Fund as educational center for mountain people. Graduate nurse; clinic building being planned; affiliation with medical center in Cincinnati for consultation and specialized services; salary $5,000 per year, with home and transportation furnished. Write Dr. Howard P. Fischbach, 1122 Carew Tower, Cincinnati 2, Ohio.

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Board Certifies 141

The American Board of Obstetrics and Gynecology, Inc., has announced that 141 candidates were certified at the annual meeting of the board in May. A requirement that case records must be forwarded to the secretary's office from 30 to 60 days after the candidate has received notice of eligibility for admission to examinations was made effective. The Board also ruled that it will not accept the nine months' residency as an academic year toward years of training requirements following the termination of the period of intern and residency acceleration on April 1, 1946. Applications will be received until November 1, 1946, for the 1947 exams. For further information write to the secretary of the board, Dr. Paul Titus, 1015 Highland Building, Pittsburgh 6.

Important "Musts" For Physician To Remember In Writing Prescription for Veteran

Officials of the Ohio State Pharmaceutical Association, which has entered into an agreement with the Veterans Administration under which veterans receiving medical care for service-connected disabilities may have prescriptions filled by fee-designated druggists, have issued a special appeal to Ohio physicians for cooperation in making the pharmacy program a success.

As announced in the August issue of *The Journal*, page 860, in which the druggists' program was outlined, only physicians who are participating as fee-designated physicians under the agreement between the Veterans Administration and the Ohio State Medical Association for medical care of veterans are eligible to write prescriptions for which the pharmacist will be reimbursed by the Veterans Administration.

In order that the druggist may be reimbursed by the Veterans Administration for filling prescriptions, the utmost cooperation of the physician is required to make certain that the following items appear on the prescription form:

1. **Date prescription is written.**
2. **Name and address of the patient.**
3. **The statement, "I am authorized to treat and prescribe for the above-named Veterans Administration patient". This statement must be signed by the physician.**

The Ohio State Pharmaceutical Association is printing special prescription forms on which to enter items 1 and 2, and with the quoted statement in item 3 already printed.

Until the physician can obtain these blanks from member-pharmacies, he should enter the statement himself. It may be printed, written, typed, or stamped, on either side of the form.

Physicians should call to the attention of their patients that these prescriptions must be filled within 10 days.

In addition to narcotic prescriptions, the physician may prescribe certain emergency supplies known as "medical requisites" as listed in the August issue of *The Journal.*

It has been reported that some physicians are neglecting to place the wording of No. 3, above, on prescriptions, causing delay in the filling of the prescription as each must contain that wording.

Wins Prize Contest

Winner of the 1946 National Gastro-enterological Association prize contest for the best unpublished manuscript on gastro-enterology or an allied subject was Captain Irving B. Brick, M.C., A.U.S., whose paper, "Radiation Effects on the Human Stomach: A Preliminary Report", was selected by the judges. The winning paper will be published in the *Review of Gastro-enterology.*



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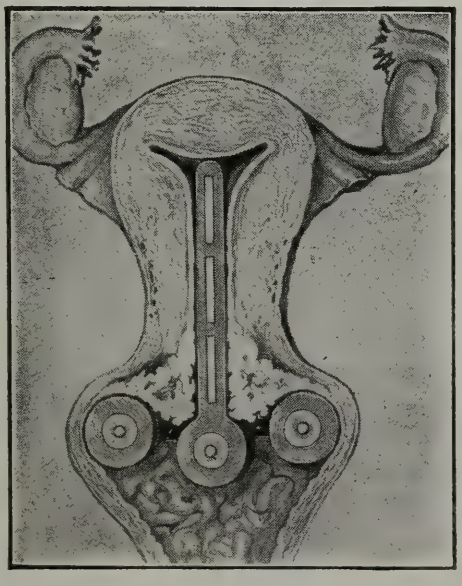
Walker products bearing A.M.A. Council acceptance are: Ascorbic Acid Tablets, 25, 50, and 100 mg.; Concentrated Oleo Vitamin A-D Drops; Thiamine HCl Tablets, 1, 3, 5, and 10 mg.; Riboflavin Tablets, 1 and 5 mg.; Niacin Tablets, 25, 50, and 100 mg.; Niacinamide Tablets, 25, 50, and 100 mg.; Hexavitamin Capsules; Vitamin A Capsules, 25,000 units; Solution Thiamine HCl (Oral).

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In Memoriam

David Darwin Alsbacher, M.D., Cleveland; University of Wooster Medical Department, Cleveland, 1904; aged 64; died July 30. Dr. Alsbacher had practiced medicine in Cleveland for about 40 years. Two sisters survive.

Albert B. Devers, M.D., Cincinnati; Miami Medical College, Cincinnati, 1896; aged 79; died August 5; former member of the Ohio State Medical Association and the American Medical Association. Dr. Devers practiced medicine in Cincinnati for nearly 50 years, for the most part at Jewish and Bethesda Hospitals. He was a 32nd degree Mason.

Samuel Edwin Findley, M.D., Mansfield; Rush Medical College, University of Chicago, 1897; aged 75; died July 13; member of the Ohio State Medical Association and the American Medical Association. Dr. Findley was the delegate from Richland County to the Ohio State Medical Association from 1919 through 1925, and in 1927 and 1929. He was president of the Richland County Medical Society in 1928. He had practiced medicine in Mansfield for about 50 years and until his retirement three years ago, he had served as chief surgeon at the Ohio State Reformatory for 20 years. He served as a first lieutenant in the medical corps of the AEF in World War I. He was a member of the Presbyterian Church and a Mason. A sister and three brothers survive.

Henry Andrew Herkner, M.D., Cleveland, University of Wooster Medical Department, Cleveland, 1906; aged 67; died July 17; member of the Ohio State Medical Association and the American Medical Association. Dr. Herkner had practiced medicine in Cleveland and in Independence, a suburb, for 40 years. He was chairman of the board at Glenville Hospital for three years and a long-time member of the staff. He was graduated from Cleveland Law School with honors in 1931. At the time of his death he was president of the Independence school board. He was a member of the Presbyterian Church and a Mason. His widow, a daughter, and a son survive.

Merril F. Jones, M.D., Canton; Ohio State University College of Medicine, 1943; aged 28; died July 20; member of the Ohio State Medical Association and the American Medical Association. With the exception of 16 months in the army, Dr. Jones had practiced in Canton since completing his internship. He was separated from service with the rank of captain in May, 1945, after serving as medical officer to a paratroop outfit in the European Theater of Operations. Surviving are his widow, his parents, two sisters, and a brother.

Max Samuel Kaplan, M.D., Canton; University of Pennsylvania School of Medicine, Philadelphia, 1925; aged 46; died July 20; member of the Ohio State Medical Association and the American Medical Association. Dr. Kaplan had practiced medicine in Canton for 10 years. Previously he had practiced for several years in Pennsylvania. His mother and three brothers survive.

Calvin Oscar Koch, M.D., Lima; University of Cincinnati College of Medicine, 1939; aged 34; died July 19; member of the Ohio State Medical Association and the American Medical Association. Dr. Koch had returned from 46 months of service as a captain in the Army Medical Corps in the Pacific, to establish practice in Lima, his home town, on July 1. He was a member of the medical commission appointed to study effects of the atomic bomb at Hiroshima, and had served in New Guinea and in the Philippines. His widow, parents, and a sister survive.

Elmer Ellsworth McPeck, M. D., Sebring, Fla.; Starling Medical College, Columbus, 1889; aged 83; died June 10; former member of the Ohio State Medical Association and the American Medical Association. Dr. McPeck retired in 1938 after having practiced in Cleveland for 45 years. He had been located previously in Bowerstown. Surviving are his widow, a daughter, and a son.

Stanley Smith Meck, M.D., Milan; Hahnemann Medical College of Pennsylvania, Philadelphia, 1927; aged 44; died July 4; member of the Ohio State Medical Association; member of the American Medical Association; issued certificate by National Board of Medical Examiners in 1928. Surviving are his widow, a son, and a daughter.

Ulysses S. Tarter, M.D., Cleveland; Meharry Medical College, Nashville, 1908; aged 65; died July 12. Dr. Tarter had practiced medicine in Cleveland for about 29 years. He was a charter member and elder of St. Mark's Presbyterian Church. His widow and two sons survive.

Charles Thompson, M.D., Mingo; University of Tennessee College of Medicine, Memphis, 1893; aged 74; died July 12; former member of the Ohio State Medical Association and the American Medical Association. Dr. Thompson had practiced medicine in Champaign County since 1928, and was county coroner at the time of his death. His widow and a stepson survive.

Granville Mobi Wright, M.D., Toledo; Long Island College of Medicine, Brooklyn, 1898; aged 75; died July 29; member of the Ohio State Medical Association and the American Medical Association. Dr. Wright was vice-president of the Henry County Medical Society in 1940, and

president in 1941. He had retired three months ago after 40 years of active practice. He served as a lieutenant in the Army Medical Corps during World War I. He was a member of the Methodist Church. Surviving are his widow, a son, a daughter, a brother, and three sisters.

Northwest Ohio Meeting Oct. 1 Hotel Shawhan, Tiffin

Ohio physicians are cordially invited to attend the 102nd meeting of the Northwestern Ohio Medical Society, Tuesday, October 1, at the Hotel Shawhan, Tiffin. The program will feature subjects of clinical interest to the practicing physician. Speakers will include Dr. Daniel J. Leithauser and a group of his colleaques from Detroit, Mich. Dr. Leithauser is well known for his work in the early ambulation of surgical patients.

A notice concerning the meeting, with final details, will be mailed to all physicians in the Third and Fourth Councilor Districts.

Officers of the society are: Dr. John M. Leahy, Tiffin, president; Dr. Robert J. Semons, Carey, vice-president; Dr. Wendell W. Green, Toledo, secretary; and Dr. E. L. Brady, Marion, treasurer.

Total of 202 Polio Cases Reported Throughout Ohio Counties

According to figures obtained from the State Department of Health the total number of cases of infantile paralysis reported in Ohio up to August 14 was 202.

This compares with 227 reported up to August 14, 1944, when there were 1,172 cases for the entire year, and 108 cases reported up to the same date in 1945, when the year wound up with only 463.

Counties where the disease has been most prevalent prior to August 14, 1946 include: Cuyahoga, with 95; Lake, 7; Summit, 18; Stark, 3; Montgomery, 18; Hamilton, 7. This totals 148 cases in six counties.

Fifty-four cases were scattered throughout 37 other counties at a rate of one, two, or three per county. More than half of the counties have reported no cases.

Of the Cuyahoga County cases, 54 were in Cleveland; 46 in surrounding metropolitan areas; and five in the general health district. Eleven of the 18 Summit County cases were in Akron; 15 of the 18 Montgomery County cases were in Dayton.



ACTIVITIES OF COUNTY SOCIETIES

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

CLINTON

At the August 6 meeting of the Clinton County Medical Society in Wilmington, approval was given to tentative plans for an 80-bed hospital to be voted on this Fall at the general election. Mr. Douglas L. Parker spoke on the subject, "Sanitation Furnished by the Health Department".—R. W. DeCrow, M.D., Secy.

Eighth District

(COUNCILOR: ARTHUR J. TRONSTEIN, M.D., NEWARK)

GUERNSEY

Dr. Arthur J. Tronstein, Newark, Eighth District Councilor of the Ohio State Medical Association was guest speaker at the meeting of the Guernsey County Medical Society, July 18 at the Berwick Hotel, Cambridge.

Dr. Tronstein spoke on the subject, "Meeting the Problems of Socialized Medicine". Dr. M. S. Lawrence, secretary of the society, presided at the meeting and Dr. Tronstein was introduced by Dr. Henry L. Wells, Cambridge.—News Clipping.

WOMAN'S AUXILIARY NEWS

By MRS. FRED W. BROSIUS, MIDDLETOWN
Chairman, Publicity Committee

NATIONAL CONVENTION

The Woman's Auxiliary to the American Medical Association met July 1-5, 1946, in San Francisco, California.

Mrs. Paul A. Davis, Akron, president of the Woman's Auxiliary to the Ohio State Medical Association, was in attendance, and reported the follows news items.

The advisory council to the National Auxiliary has been abolished, and hereafter, the officers and the directors of the National Auxiliary will meet with the entire Council and Officers of the A.M.A. at least once a year. The Ohio representatives were in accord with this change and may consider such a plan for the State Association at some future time.

Mrs. J. L. Stevens, Mansfield, a director of the National Auxiliary, was elected to the nominating committee for 1947.

Ohio was first in *Bulletin* subscriptions with a total of 322. Pennsylvania was second with 219.

Ohio is now fifth in Auxiliary membership, with over 1,517 members.

Ohio was the first state to adopt a Conference of County Presidents, Presidents-elect, and Chairmen of State Committees. Action was

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taken by the national board to have all states adopt a similar conference, due to the fact that Ohio's met with such great success last year.

Officers and delegates attending from Ohio were: Mrs. C. B. Gillette, secretary and delegate, Toledo; Mrs. Gilbert Micklethwaite, delegate, Portsmouth; Mrs. David Heusinkveld, delegate, Cincinnati; Mrs. Dale P. Osborn, delegate, Cincinnati; Mrs. C. J. Holly, delegate, Bridgeport; Mrs. J. R. Tillotson, delegate, Lima; Mrs. John Franklin, delegate, Chillicothe; Mrs. Paul A. Davis, president, Woman's Auxiliary to the Ohio State Medical Association; Mrs. J. L. Stevens, director, the National Auxiliary.

STATE BOARD MEETING AND CONFERENCE

The annual Fall Board Meeting and Conference of Presidents, Presidents-elect, and Chairmen of State Committees, will be held at the Deshler-Wallick Hotel, Columbus, September 18 and 19.

The meeting will convene in Parlors A, B, and C, at 9:45 A. M., Wednesday, September 18, with Mrs. Paul A. Davis, president, in the chair. Reports and discussions by county presidents, presidents-elect, and chairmen of state committees will be the main feature on the agenda.

On Thursday, September 19, the members of the board of directors will enjoy a breakfast, at which time Mr. Charles S. Nelson, executive secretary to the Ohio State Medical Association, will speak.

Mrs. Paul A. Davis, president, will open the business session at 9:30 A. M. Reports by state officers and chairmen will follow and a luncheon is planned for the conclusion of the meeting.

State officers for the year 1946-47 are as follows: Mrs. Paul A. Davis, president; Mrs. Harold K. Mauser, president-elect; Mrs. R. L. Rutledge, vice-president; Mrs. E. B. Gillette, secretary; Mrs. Dean Nesbit, treasurer; Mrs. Roswell S. Fidler, past-president.

District Directors: Mrs. W. B. Roads, 1st; Mrs. E. P. Trittschuh, 2nd; Mrs. J. R. Tillotson, 3rd; Mrs. Rolin Kuebbler, 4th; Mrs. A. M. Mills, 5th; Mrs. J. J. McDonough, 6th; Mrs. J. W. Calhoon, 7th; Mrs. T. R. Mattocks, 8th; Mrs. G. E. Neff, 9th; Mrs. G. W. Cooperrider, 10th; Mrs. C. H. Bell, 11th.

Chairmen of Standing Committees: Mrs. Roswell S. Fidler, finance; Mrs. B. C. Diefenbach, hygeia; Mrs. D. L. Beers, program; Mrs. C. F. Wharton, legislation; Mrs. D. M. Keating, public relations; Mrs. J. L. Stevens, historical; Mrs. Harold K. Mauser, organization; Mrs. Fred Brosius, publicity.

Chairmen of Special Committees: Mrs. Farrell T. Gallagher, convention; Mrs. R. W. Hoffman, Nurse's Loan Fund; Mrs. Frank Riebel, bulletin and handbook; Mrs. R. M. Wilson, members-at-

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Four Weeks Course in GENERAL SURGERY starting September 9, October 7.

One Week Course in SURGERY OF COLON & RECTUM starting September 16, October 14.

One Week Course in THORACIC SURGERY starting September 23.

GYNECOLOGY — Two Weeks Intensive Course starting October 21.

One Week Personal Course in VAGINAL APPROACH TO PELVIC SURGERY starting September 16, October 14.

MEDICINE—Two Weeks Intensive Course starting September 23, October 21.

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FRANKLIN COUNTY

Mrs. Earl H. Baxter, 2300 Tremont Rd., Columbus, president of the Woman's Auxiliary to the Columbus Academy of Medicine will have the following officers and chairmen for the ensuing year:

Mrs. Frank Riebel, vice-president; Mrs. Donald Bullock, recording secretary; Mrs. H. C. A. Beach, corresponding secretary; Mrs. R. E. Krigbaum, treasurer; Mrs. D. J. Alspaugh, president-elect.

Mrs. John Riebel, calendar; Mrs. James Warren, hospitality; Mrs. Howard Boucher, hygeia and bulletin; Mrs. H. M. Clodfelter, inter-relations; Mrs. Ralph Hoffman, legislative; Mrs. Charles Pavey, membership; Mrs. Horace Davidson, music; Mrs. Miner Seymour, program; Mrs. Earl Ryan, project; Mrs. William Miller, social; Mrs. Forrest Keiser, telephone; Mrs. Floyd Green, transportation; Mrs. Ralph Ramey, ways and means; Miss Allyne Stout, historian; Mrs. Albert Landrum, Mrs. I. B. Harris, auditors; and Mrs. O. W. Jepsen, publicity.

SUMMIT COUNTY

A picnic was enjoyed by Summit County Auxiliary members and their husbands at Mingo Camp in Metropolitan Park. Mrs. E. A. Simendinger and Mrs. W. A. Keitzer were chairman and co-chairman. The former recently gave a tea at her home for the committee. Other members were Mrs. V. C. Molloy, Mrs. Harold Klinger, Mrs. Lloyd Catron, Mrs. J. C. Damitz, Mrs. J. W. Johnson, Mrs. D. C. Snyder, Mrs. R. E. Williams, Mrs. H. R. Groppe, Mrs. L. L. LaMonica, Mrs. Ross Zeno.

The Summit County Auxiliary has selected for its major project this year, a Student Nurses' Scholarship Fund. In order to increase the fund it will be necessary to raise a large sum of money during the coming season. The auxiliary will assume sponsorship of a series of five plays to be given at Billie Lahrmer's new Spotlight Playhouse. The first play is scheduled for September 13. Mrs. M. F. Bossart is chairman of the ways and means committee. Working with her are Mrs. V. C. Malloy, Mrs. C. C. Nohe, Mrs. Robert Lemmon, and Mrs. J. P. Goetz.

Mrs. Donald M. Traul, president of the auxiliary, has announced the following appointments: Mrs. F. H. Cook, membership; Mrs. E. A. Simendinger and Mrs. W. A. Keitzer, social; Mrs. R. M. Lemmon, public relations; Mrs. Arnold Gold, program; Mrs. J. P. Sauvageot, finance; Mrs. W. R. Reichsteiner and Mrs. H. Gibson, telephone; Mrs. E. W. Grubb, hospitality; Mrs. J. M. Ulrich, medical collection; Mrs. C. C. Nohe, student nurse scholarship; Mrs. C. F. Wharton, legislation; Mrs. S. W. Stauffer, Tuberculosis Clinic;



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Mrs. E. W. Breyfogle, parliamentarian; Mrs. John Bacos, auditor; Mrs. W. T. Bucher, transportation; Mrs. R. L. Ross, sunshine; Mrs. W. J. Pittinger, hygeia; Mrs. E. M. Rowland, gift; Mrs. V. C. Molloy, publicity; Mrs. R. T. Allison, scrap book; and Mrs. E. L. Voke, bulletin.

Officers are: Mrs. D. M. Traul, president; Mrs. R. M. Lemmon, president-elect; Mrs. A. V. Gold, vice-president; Mrs. J. P. Sauvageot, treasurer; Mrs. F. M. McDonald, recording secretary; Mrs. R. Sommerfield, corresponding secretary; Mrs. V. C. Molloy, delegate and pres.-elect, Mrs. J. P. Goetz and Mrs. M. F. Bossart, alternates.

A tea for new members will be an event of September 3. Reported by Mrs. V. C. Malloy, 2038 White Pond Drive, Akron.

PRESIDENTS OF COUNTY AUXILIARIES

DISTRICT 1

BUTLER—Mrs. C. J. Chamberlain, 501 Beal Ave., Hamilton
CLINTON—Mrs. Kelley Hale, 626 W. Main, Wilmington
HAMILTON—Mrs. David Heusinkveld, 3 Interwood, Cincinnati
HIGHLAND—Mrs. W. B. Roads, 209 S. High, Hillsboro

DISTRICT 3

ALLEN—Mrs. M. A. Mulvania, 120 Dale Drive, Lima
HANCOCK—Mrs. Frank M. Wiseley, 521 Sandusky St., Findlay
MARION—Mrs. Clare W. Smith, 651 Vernon Height Blvd., Marion

DISTRICT 4

LUCAS—Mrs. N. B. Muhme, 2030 Potomac Dr., Toledo

DISTRICT 5

ASHTABULA—Mrs. A. M. Mills, 2043 East 44th St., Ashtabula
CUYAHOGA—Mrs. F. T. Gallagher, 1423 W. Clifton Blvd., Lakewood

DISTRICT 6

COLUMBIANA—Mrs. Seward Harris, 377 E. Lincolnway, Lisbon
MAHONING—Mrs. L. G. Coe, R.F.D. 2, Canfield
SUMMIT—Mrs. Donald M. Traul, 1646 Twenty-sixth St., Cuyahoga Falls
TRUMBULL—Mrs. David L. Beers, 661 Mahoning Ave., Warren
STARK—Mrs. Edward C. Reno, 800 18th St., N. W., Canton

DISTRICT 7

BELMONT—Mrs. C. J. Holley, 11 Elm St., Bridgeport
HARRISON—Mrs. J. M. Scott, Scio
TUSCARAWAS—Mrs. P. D. Hisrich, Bolivar

DISTRICT 8

WASHINGTON—Mrs. W. S. Hawn, 712 Washington St., Marietta

DISTRICT 9

SCIOTO—Mrs. W. M. Singleton, 1627 Galena Pike, Portsmouth

DISTRICT 10

FRANKLIN—Mrs. Earl H. Baxter, 2300 Tremont Rd., Columbus
KNOX—Mrs. James T. Lee, 607 Main St., Mt. Vernon
ROSS—Mrs. Harold Crumley, 84 W. Second St., Chillicothe

DISTRICT 11

ASHLAND—Mrs. Herman Gunn, 104 E. Walnut St., Ashland
RICHLAND—Mrs. Leopold Adams, 800 Wood Hill Road, Mansfield

At the recent annual session of the American Medical Association, the House of Delegates adopted a resolution approving the establishment of General Practice Sections in the state and county medical societies. The resolution was sponsored by the Section on General Practice of Medicine, of which Dr. Paul A. Davis, Akron, is the new chairman, and Dr. J. Craig Bowman, Upper Sandusky, a former chairman, is a member of the Executive Committee.

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COMING MEETINGS

Ohio State Medical Association, Cleveland, May 6-8, 1947.

American Medical Association, Atlantic City, June 9-13, 1947.

American Association on Mental Deficiency, Montreal, Canada, Oct. 2-4.

American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Hot Springs, Va., Sept. 5-7.

American College of Physicians, Chicago, April 28-May 2, 1947.

American College of Surgeons, Cleveland, Dec. 16-20.

American Congress of Physical Medicine, New York City, Sept. 4-7.

American Diabetes Association, Toronto, Canada, Sept. 16-18.

American Dietetic Association, Cincinnati, Oct. 14-18.

American Hospital Association, Philadelphia, Sept. 30-Oct. 3.

American Public Health Association, Cleveland, Nov. 12-14.

American Roentgen Ray Society, Cincinnati, Sept. 17-20.

International College of Surgeons, U. S. Chapter, Detroit, Oct. 21-23.

Association of Military Surgeons of the United States, Detroit, Oct. 9-11.

Northwestern Ohio Medical Society, Tiffin, Oct. 1.

Interstate Postgraduate Medical Association, Cleveland, Oct. 15-18.

Mississippi Valley Medical Society, Sept. 25-27, St. Louis.

National Society for the Prevention of Blindness, New York, Nov. 25-27.

Congress on Industrial Health, Boston, Sept. 30-Oct. 3.

Programs To Commemorate Discovery of Insulin 25 Years Ago

The twenty-fifth anniversary of the discovery of insulin will be observed with a program in Convocation Hall, at the University of Toronto, on September 16. Many internationally known figures in the field of medicine will be present to honor the occasion. Among them will be R. D. Lawrence, physician in charge, Diabetic Clinic, Kings College Hospital, London, England; H. C. Hagedorn, of Gentofte, Denmark; Bernardo A. Houssay, Research Institute of Experimental Biology and Medicine, Buenos Aires, Argentina; and Elliott P. Joslin, Harvard Medical School, Boston, U.S.A. This observation will be followed by the regular annual meeting of the American Diabetes Association.

On September 23, Eli Lilly and Company will sponsor an international diabetes clinic to be

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held at the Indiana University Medical Center in Herty Hall of the State Board of Health Building, Indianapolis. International importance will be given to this meeting by the presence of Professor Charles H. Best, Toronto, Canada, co-discoverer with Banting of insulin, Professor Houssay, Dr. Lawrence, and Dr. Hagedorn. They will discuss various phases of diabetic care. Other speakers will include: Dr. Joseph H. Barach, Pittsburgh; Dr. John R. Williams, Rochester, N. Y.; Professor Carl Cori, St. Louis; and Dr. Joslin.

Do You Know - - -

The Executive Board of the American Public Health Association has accredited schools of public health in the following institutions to give the degree of Master of Public Health (Diploma of Public Health in Canada) for the academic year 1946-1947; Columbia University; Harvard University; Johns Hopkins University; University of California; University of Michigan; University of Minnesota; University of North Carolina; Yale University; University of Toronto.

* * *

Rear Admiral Joel T. Boone, U. S. Navy Medical Corps, is directing a survey and study of hospital and medical facilities, medical treatment, sanitation, community facilities, and housing in the coal mining areas of the country. The survey was made necessary by provision of a Medical and Hospital Fund in the wage agreement of the United Mine Workers of America and the bituminous coal operators.

* * *

The Washington Institute of Medicine, Washington, D. C., has announced the publication of a new journal, the *Quarterly Review of Dermatology and Syphilology*. The editors are Dr. Donald M. Pillsbury, editor-in-chief; Dr. Herman Beerman and Dr. Clarence S. Livingood, associate editors. The journal will survey all published material on dermatology and syphilology appearing anywhere in the world from January 1, 1946 onward.

* * *

Marquette University School of Medicine, Milwaukee, will sponsor an orientation course in clinical allergy under the auspices of the American Academy of Allergy, Oct. 7-11. Inquiries should be addressed to Dr. Eben J. Carey, dean, Marquette University School of Medicine, Milwaukee 3.

* * *

The brilliant victory of medical science and public health administration over typhoid fever is related in the June issue of *Statistical Bulletin*, published by the Metropolitan Life Insurance Company. The disease has dropped from a lead-

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ing cause of death at the turn of the century to one of negligible importance numerically. In 1900, the death rate from typhoid and paratyphoid fever was in excess of 30 per 100,000 population; in 1944, it was only 0.4, a decline of 99 per cent.

* * *

In 1945 there were only 346 cases of smallpox reported in the United States, including eight in Ohio. In 1930 there were 48,920 cases reported in the entire country. Of these, 5,116 were in Ohio.

* * *

In the United States during the year 1944, there were 19,703 persons who died from respiratory tuberculosis outside of hospitals and institutions. The figure represents 36 per cent of the total deaths from the disease.

* * *

Dr. Charles C. Higgins, Cleveland, has been elected secretary-treasurer of the American Association of Genito-Urinary Surgeons.

* * *

Dr. R. L. Rutledge, Alliance, President-elect of the Ohio State Medical Association, spoke on "Socialized Medicine" at a recent meeting of the Sebring Rotary Club.

* * *

Dr. William J. Gardner, Cleveland, spoke on "Diagnosis and Nontraumatic Intracranial Lesions", at a recent meeting of the Tenth and Eleventh Councilor Districts of the Pennsylvania State Medical Society at Washington, Pa.

* * *

Dr. Mabel E. Gardner, Middletown, was elected vice-president of the American Medical Women's Association at the recent annual meeting in San Francisco.

Surgical Assembly on Oct. 21-23

An international surgical assembly sponsored by the United States Chapter, International College of Surgeons, will be held at Detroit, Oct. 21-23. Details of the intensive clinical and didactic program by world authorities will be found on page 981 of this issue of *The Journal*.

All doctors of medicine in good standing are cordially invited. A copy of the program, information concerning the Assembly, and the primary qualifications for Fellowship in the I.C.S., are available by writing Dr. L. J. Gariepy, secretary, 16401 Grand River, Detroit 27.

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JONATHAN FORMAN, M.D., *Editor*

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The Management of Malaria

THOMAS P. SHARKEY, M.D.

THE return to civilian life of military personnel, many of whom have had malaria, has caused active speculation as to whether or not there will be an increase in human malaria, or an introduction of new strains of malaria in this country.

While malaria had been widespread throughout this country in past years, it had decreased during prewar years and was restricted largely to certain endemic areas in the south. It is theoretically possible to reintroduce malaria into almost all parts of the country, since anopheles mosquito vectors are present to some extent in all of the states. Inhibitory factors such as improved housing, sanitation, more effective mosquito control, and effective malarial therapy have rendered most of the United States malaria-free. Sufficient time has already elapsed since the return of thousands of infected military personnel to show that while the potentiality exists for a spread of malaria it has been held effectively in control. In the middle of 1943, Naval Hospitals in the United States had a large census of malaria patients but in slightly over a year later very few cases of malaria were encountered.

It is unlikely that falciparum malaria will be imported into the United States, except under such unusual conditions as air travel. One such case was reported recently by Shookhoff and Strax[1] occurring in a patient who had flown from London to New York via West Africa. According to Butler and Sapero,[2] relapse rates from falciparum malaria are less than 5 per cent, and most of the cases of Pacific falciparum malaria were cured in the several weeks to months intervening between exposure and return to the United States. These same authors state that quartan malaria has been a negligible factor, comprising less than 1 per cent of the total cases of malaria. Plasmodium vivax is responsible for the type of chronic recurrent malaria that will be seen most commonly. Pacific vivax malaria is extremely chronic and is prone to produce frequent recurrences over prolonged periods of time. According to Butler and Sapero, Pacific malaria will recur two or three times as often as domestic benign tertian malaria. These authors also point out that while the American negro of the South has revealed a well-known tolerance to domestic malaria, in the South Pacific there was equal susceptibility of the negroes and whites to the Pacific strain of vivax malaria. Furthermore, the tendency toward relapse was approximately equal in both groups.

These authors make these important observations:

"1. Due to its prolonged course, numbers of vivax malaria cases have already returned from the Pacific. However, these cases are subsiding and it is thought that few cases will last beyond two years.

"2. No appreciable transmission of malaria

The Author

● **Dr. Sharkey, Dayton, Ohio, is a graduate of University of Cincinnati College of Medicine, 1930; life member, Am. Coll. of Physicians; member, Am. Diabetes Assn.; on senior staff, internal medicine, Miami Valley Hospital; and consultant, Dayton State Hospital.**

Presented at the First General Session of the Centennial Anniversary Meeting of the Ohio State Medical Association. Columbus, May 7-9, 1946.

from troops to civilians has occurred despite the presence of these cases in this country.

"3. The Pacific strain or strains of benign tertian malaria differ from domestic vivax malaria in certain respects, notably the tendency of the Pacific strain to frequent attacks, poor response to standard therapy, and its effect on the American negro.

"4. The danger in regard to Pacific vivax malaria is not that it will cause malaria to become widespread over the country again, but that a new and virulent strain or strains of vivax malaria may be introduced.

"5. The only population groups possibly to be affected appreciably are those in endemic malarial areas."

SELF LIMITED

Coggeshall[3] reports: "There seems to be no doubt that this South Pacific malaria is a self-limited disease and will eventually disappear. Actually, within a relatively short six-month period, we are noticing that a curve representing the rate of recrudescences has a definite downward trend in this malaria, that is still manifesting itself in the third year after inception, and a program of physical fitness is precipitating the fall of the curve."

Coggeshall also states that arsenicals or other heavy metals, sulfonamides, penicillin, dyes, or other types of compounds are in general of little or no avail.

According to Heering and Harris,[4] the cases of malaria reported to the Ohio State Department of Health from 1939-1946 are as follows:

1939	26
1940	45
1941	15
1942	8
1943	40
1944	151
1945	105
1946	264

(to April 22nd)

It is difficult to draw any accurate conclusions from these figures inasmuch as all cases of malaria probably have not been reported and there has been no distinction made to the State Department of Health as to whether the cases were of foreign or domestic origin. However, despite these discrepancies it is most likely that the increase of malaria cases reported, especially this year, represent foreign-acquired malaria in our returned military personnel. On the basis of our present knowledge it is doubtful that there has been any increase in domestic malaria in the State of Ohio, despite the existing reservoir of malarial infection for such an increase.

OHIO MOSQUITOES

The species of anopheles mosquitoes most commonly found in Ohio, according to Venard,[5] are punctipennis, quadrimaculatus, walkeri, and barberi. Venard states that **Anopheles punctipennis** is the one most commonly encountered in the State and that it can be found in almost any vicinity. This particular species of anopheles breeds in standing or running water and the water may be quite cold. It is found relatively early in Spring and thrives until early Fall. While Anopheles punctipennis is a good vector of plasmodium vivax, it is fortunately not apt to prove of serious epidemiological concern as a transmitter of human malaria because it prefers as its hosts cattle and horses.

Anopheles walkeri is another species of anopheles found in Ohio, particularly in the northern sector where it is more abundant than quadrimaculatus. Anopheles walkeri breeds in cooler water and is most abundant in July, August, and early September. According to Venard, while Anopheles walkeri is a good vector of experimental malaria, its relationship to the transmission of human malaria needs further study, despite the fact that a natural infection in this species was discovered in Tennessee.

Anopheles barberi is the most rare species found in Ohio although its distribution is widespread. This species breeds in water held in cavities found in trees, stumps, and hollow logs. It is commonly found in the vicinity of residential areas and while it is a good vector of experimental malaria, Venard does not believe that this species will be an important factor in the transmission of human malaria.

Anopheles quadrimaculatus is not nearly so commonly found as Anopheles punctipennis but it is the most dangerous of all the species as far as the transmission of human malaria is concerned. It is abundant only under certain local conditions. This species breeds in warm water, water that is stagnant, and is usually not found in streams. It has been found around some of the lake regions and is most abundant in the warm Summer months. This species is a good vector of human malaria since it readily feeds on human beings. Watson[6] in a recent study determined that Pacific strains of plasmodium vivax can be transmitted by Anopheles quadrimaculatus.

The impounding of large sources of water by industries, the damming of waters by the State for fishing and recreational purposes, and the installation of summer camps near sources of quiet water, all provide potential sources of danger for the transmission of malaria providing adequate mosquito control is not carried out.

Russell[7] states: "The greatest social obstacle to malaria prophylaxis in the world today is the lack of suitable malaria control organizations. But it has already been proved that under civil conditions malaria transmission can be completely stopped at a price within the economic reach of many rural communities even in the tropics. Allied malaria control units have demonstrated

the value of malaria control by modern methods all over the world with such striking success that civilian authorities are more willing than ever before to budget funds for antimalaria programs."

So far as the author has been able to ascertain no systematic entomological survey has been made by the State of Ohio. The reports that are now available are those made by individuals. The problem of malaria control in the State of Ohio needs to be directed towards effective mosquito control. The role of the entomologist in a program of this type is all important and many unnecessary and inadequate steps can be avoided by the proper use of the entomologist. The value of this type of study was seen over and over again in the Pacific campaign.

BIOLOGICAL FACTS

A knowledge of the biology of the malarias is necessary in order to understand the problems involved in the treatment of this disease.

It had been thought for a long time, according to the idea of Schuadinn, that the sporozoites upon introduction into the peripheral blood vessels immediately enter red blood cells, round up and become signet ring forms. The evidence today points to an entirely different concept, namely, that for the first six to seven days following the introduction of the sporozoite these parasites occur outside the red blood cells. According to Huff,[8] recent work with some of the experimental avian infections which have somewhat similar characteristics to human malaria have clarified the underlying disease mechanisms. In the light of this work it seems likely that when the sporozoites are deposited locally by the infected anopheles mosquito, they are taken up by tissue macrophages, while those which gain entrance to the circulating blood are taken up by other portions of the macrophage system of the body. Upon entry into a macrophage the sporozoite rounds up and undergoes rapid growth. They multiply by a series of segmentations, sporulations, and reinvasions which at this stage of the disease is presumably confined to the macrophage system. This process covers a six to seven-day period during which time the blood is devoid of demonstrable parasites.

At the end of this period, certain of the tissue forms undergo another type of segmentation which results in the production of new forms of the parasite. These are capable of invading, growing, and multiplying in the red blood cell. Growth in the erythrocytes is accompanied by periodic segmentation, sporulation, and reinvasion of new erythrocytes in what is called the schizogenous or asexual cycle of the parasite. This process continues with a progressive increase in the numbers of parasites in the blood until about fourteen days after the day of infection in vivax and falciparum malaria when a sufficient density of parasites is reached to produce the fever which characterizes the clinical attack.[9a,b,d] The duration of the incubation period in quartan malaria is of somewhat uncertain duration but it is usually longer than that of vivax or falciparum malaria.[9c]

THE UNTREATED CASE

The subsequent course of the untreated disease is governed to a certain extent by the species of plasmodium involved and by the presence or absence of natural or acquired immunity. Falciparum malaria in the absence of therapy or immunity is characterized by a short, fulminating, and not infrequently fatal course with little tendency toward true relapses subsequent to the termination of the initial period of activity. Vivax malaria is characterized by a longer initial course of clinical activity which, if untreated, frequently lasts more than six weeks, and by one or more relapses which may occur at intervals of a few weeks to several months. However, this type of malaria almost never results in a fatal outcome if untreated. Quartan malaria is characterized by a very long period of initial clinical activity, and this is followed by infrequent relapses which may occur many years after the initial attack.

The sexual forms of the parasite or the gametocytes are derived from the asexual cycle of the erythrocytic phase of the disease.[9] While these forms are unimportant from the standpoint of the progress of the disease, they are responsible for the transmission of the disease from man to the anopheles mosquito.

These considerations are important from the standpoint of therapy. It seems likely on the basis of present information that the continued presence of the underlying tissue forms is responsible for the relapses in vivax malaria, due to subsequent sporulations each of which may result in a reinvasion of the blood with the successful re-establishment of the erythrocytic forms. The usual lack of numerous relapses in falciparum malaria may be presumed to be due to the lack of persisting tissue forms. Little is known of the biological characteristics of quartan malaria with respect to the presence or absence of such tissue forms as a necessary factor in the production of true relapses.

THERAPY

A. Quinine. It is unlikely that quinine will be used to any great extent in the future treatment of malaria especially in this area. Recent work[10] has confirmed the belief that the cinchona alkaloids other than quinine, i.e., cinchonine, cinchonidine, and quinidine, have an antimalarial activity which is roughly the equivalent of quinine. It is to be expected that the combination of these alkaloids in the form of a standard prod-

uct such as totaquine, U.S.P., also will have roughly the same antimalarial activity as quinine. The cinchona alkaloids are not localized as extensively in the tissues as quinacrine and therefore their use in the suppression and treatment of malaria will differ from that of quinacrine. The less extensive localization together with more rapid rates of excretion and degradation results in a rapid fall in plasma levels of the cinchona alkaloids when oral dosage is stopped. As a result of this, relatively lower initial doses as compared to the maintenance doses are required to produce the desired result.

Quinine is a highly effective antimalarial but its antimalarial activity is less than that of quinacrine when the latter is properly used.[11] The maximum benefit to be derived from quinine in the acute attack should be obtained by the administration of three grams of one or another of the available salts of quinine during the initial day of therapy followed by two grams daily in divided doses. Therapy may be limited to a seven-day period in vivax malaria and perhaps to a ten-day period in quartan and falciparum malaria. It may be necessary in patients with fulminating falciparum malaria, cerebral malaria, or in those patients with marked nausea and vomiting, to resort to intravenous therapy. This can be done by administering slowly intravenously not more than 0.5 gram of quinine in 250 to 500 cc. of physiologic salt solution in a single infusion to be repeated as necessary. In such cases one should supplant parenteral therapy as soon as possible with oral therapy. Quinine should not be given intramuscularly.

For suppressive purposes, it is necessary to administer as much as one gram of a quinine salt daily to approach a therapeutic result which is comparable to that which one obtains when 0.1 gram of quinacrine is administered daily, according to Shannon and Earle.[10] These authors state that it is less certain that suppressive quinine used in accordance with these directions will effect cures of the suppressed falciparum malaria.

B. Quinacrine hydrochloride (atabrine), the dihydrochloride of 3-chloro-7-methoxy-9-(1-methyl-4-diethyl-amino)-butylamino acridine. This synthetic compound was first prepared by Meitzsch and Mauss, 1930, at Elberfeld. It is a yellow crystalline substance which dissolves in water at 40 degrees centigrade in a 7 per cent solution.

The loss early in the course of the recent war of our major source for the supply of quinine led to a re-evaluation of the potentialities of quinacrine by the Board for the Coordination of Malarial Studies.[10] During the early course of the war, the use of quinacrine was not clearly understood and as a result of this there were many conflicting early reports on the use of this drug. As a result of intensive study by the Board for the Coordination of Malarial Studies they have recently stated: "It was clearly apparent that atabrine, when used properly, is a highly effective agent and one which is superior to quinine for the routine management of the malarias.[10,11,12]

As a result of the study of quinacrine it has been found that quinacrine is almost completely absorbed from the gastro-intestinal tract and that renal excretion accounts for very little of the daily dose.[10] It may be concluded from these facts and from the fact that its plasma concentration becomes stabilized after several days of drug administration at a constant dosage, that it is disposed of by the body mainly by processes which result in its degradation. Early in the course of the investigation, a method for the determination of quinacrine in the plasma was developed by Brodie and Udenfriend.[13] As a result of this it was found that the erythrocytic forms of blood induced plasmodium vivax (McCoy strain) are completely and permanently eradicated when plasma quinacrine levels of 30 micrograms per liter or more are maintained for not less than four days. Plasma quinacrine levels between 10 and 30 micrograms per liter generally produce temporary or partial effects and levels below 10 micrograms per liter produce little or no effect when only maintained for a similar four-day period. The erythrocytic forms of blood induced plasmodium falciparum (McClendon) strain appear to be more resistant and require approximately 50 micrograms per liter maintained for a six-day period for eradication.[14]

Studies on the distribution of quinacrine in experimental animals revealed that the drug may attain concentrations in the liver and spleen as high as 10,000 to 20,000 times those concurrently observed in plasma.[10] The concentration of the drug in plasma, erythrocytes, and leucocytes is in the order of 1 to 1, to 100 to 200. This excessive localization of quinacrine in the leucocytes acquires special importance in studies which would assay the inherent antimalarial activity of the drug, or would delineate the factors concerned with its physiologic disposition. Its concentration in whole blood at any time during a period of therapy is dependent as much or more upon the leucocyte count as upon the underlying chemotherapeutically active concentration in the blood plasma. It may be noted in passing that the major portion of quinacrine in the plasma is bound to the non-diffusible constituents in the plasma, presumably the plasma albumin.[10] Localization in other tissues was found to be less extensive. It was thus demonstrated that a major portion of administered quinacrine is localized in the tissues of the body, leaving little in the plasma to exert a chemotherapeutic effect. Thus if large initial doses of the drug are not given, the initial plasma concentration remains

low. However, the extensive localization together with the low rates of degradation and renal excretion lead to a low rate of decline of the quinacrine plasma concentration and consequently a low rate of loss of the protection conferred by quinacrine subsequent to the termination of the drug administration.

According to Shannon, et al.,[12] the correlation between the oral dosage and plasma quinacrine levels is poor so that it is difficult to state the antimalarial activity of the drug in terms of oral dosage. However, it is possible to estimate the dosage on the basis of these studies for the maximum benefit to be derived from the drug in all but the exceptional individual. Shannon and Earle[10] recommend that in the routine treatment of malaria that 0.2 gram doses of quinacrine be given at the time of diagnosis of malaria and at four-hour intervals until a dosage of 1.0 gram has been given. Thereafter it should be continued at a dosage level of 0.1 gram three times daily for a period of seven days. High initial quinacrine plasma concentrations are obtained by this initial high dosage and can be maintained thereafter by 0.1 gram three times daily for a total period of seven days. In acutely ill patients with fulminating falciparum malaria, pernicious malaria, or in those in whom nausea and vomiting predominate, intramuscular injections of quinacrine are effective. It is customary in such conditions to give 0.2 gram of quinacrine dihydrochloride in each buttock. High effective plasma concentrations are obtained within fifteen minutes after intramuscular injection of 0.4 gram of quinacrine dihydrochloride.[14]

Oral therapy should be instituted as soon as possible and Shannon and Earle[10] recommend that following the intramuscular injection of 0.4 gram of quinacrine dihydrochloride that 0.2 gram be administered at 8-hour intervals until a total of 1.0 gram has been administered; then at 12-hour intervals until it is possible to begin oral therapy with 0.1 gram three times daily. When oral therapy is combined with intramuscular therapy, 0.2 gram doses of quinacrine can be given orally every four hours until a total of 1.0 gram has been given by a combination of the two routes. Thereafter, 0.1 gram is given three times daily for seven days. If adequate doses of quinacrine are given it is unusual for a patient to experience more than one subsequent paroxysm. A cure of the disease can be expected in most patients with falciparum malaria but not in patients with vivax malaria. The majority of patients with vivax malaria will relapse within one to twelve months.

SUPPRESSIVE THERAPY

Suppressive therapy is not likely to be required in this area. In patients who have been exposed for a period of months to malaria, attacks of clinical malaria can be suppressed by the daily administration of 0.1 gram of quinacrine. The delayed primary attacks as well as the clinical relapses may be treated in the same manner as the primary attacks. In general, the relapses respond more readily to therapy than the primary attack and a greater parasite density of the blood is required to evoke an attack. The real problem is the patient with vivax malaria who has numerous relapses at short intervals. These patients do well when maintained on suppressive therapy for a period of several months or more. There is little information on the ultimate effect of this type of therapy. The suppression of the erythrocytic phase of the disease permits the patient to pursue a normal life, but the tissue phases will progress through their normal life expectancy.

Quinacrine should be given after a full meal since it is less likely to produce gastro-intestinal symptoms. There have been many reports on the toxicity of quinacrine, including transient psychoses, hepatic necrosis, epileptiform convulsions following intramuscular injections, and more recently, Livingood and Dieuaide[15] have described a skin condition resembling lichen planus due to quinacrine intoxication, which has acquired the name atypical lichen planus. These same authors have reported a primary exfoliative dermatitis due to quinacrine sensitivity. However, untoward reactions possibly due to the drug have been few considering the large numbers of individuals who have taken it and the long periods of time during which it has been administered. When given in the manner and the dosage indicated and based upon the plasma blood levels that have established such doses toxic reactions should be minimal.

In a report on the study of the toxicity of quinacrine, Bispham[16] presented data on 49,681 cases of malaria in which quinacrine had been administered. In only 38 of these was there a severe toxic reaction. Gastro-intestinal disturbances occurred in those revealing toxic manifestations. The gastro-intestinal symptoms were less frequent if from 10 to 15 grains of sodium bicarbonate are given with each dose of quinacrine. Mild depression and transient psychoses may occur but the reports indicate that the incidence of quinacrine psychosis may be placed tentatively at less than 0.1 per cent. According to The Bureau of Medicine and Surgery of the Navy,[17] it has been shown that quinacrine "if given to dogs in doses sufficient to maintain a plasma level of 1,000 micrograms per liter for a period of three months, will produce hepatic necrosis. The usual therapeutic regimen (300 mg. each day) results in an average plasma level of 50 micrograms per liter. Theoretically, a dose of atabrine sufficient to produce hepatic dam-

age is at least ten times the therapeutic dose." In another experiment, 50 patients who had averaged 9.7 relapses of malaria and 13 of whom had had previous clinical jaundice were given 4.5 grams of quinacrine over a ten-day period.[17] There was little evidence that quinacrine in the doses employed exerted much, if any, hepatoxic action. Many investigators believe that there is some accompanying hepatic damage in all initial and recurrent attacks of malaria. This group would have appeared particularly susceptible to any hepatoxin that quinacrine might possess.

If one takes the formula for quinacrine and removes either of the outer rings, one obtains two 4-aminoquinolines, one with a methoxy group in the 6-position and one with a chlorine group in the 7-position. The first of these compounds belongs to a series which, in its antimalarial properties, resembles quinine and quinacrine rather than the 8-aminoquinoline, pamaquin.[18]

About 200 compounds in the 4-aminoquinoline group, with variations in nucleus as well as in side chain, have been screened for antimalarial activity in at least one avian infection, and about ten of these 4-aminoquinolines have been examined, first for toxicity in the dog and monkey, and then for antimalarial activity and toxicity in the human being. Several of these ten compounds appear to be superior to quinacrine. One of these, SN 7618, has received the most extensive study in both civilian and military establishments.[18]

C. Chloroquine (SN 7618) 7-chloro-4-(4-diethylamino-1-methylbutylamino) quinoline. An intensive exploration of the effects of SN 7618 on animals and man has been in progress during the past two years, according to Loeb, et al., of the Board for the Coordination of Malarial Studies.[19]

As a result of these studies it has been shown that the absorption of SN 7618 from the gastro-intestinal tract, like that of quinacrine, is complete or nearly complete. It is absorbed somewhat more rapidly than quinacrine and, because of lesser localization, is present in substantially higher concentrations than quinacrine on any given dosage schedule. The excretion of SN 7618 is slightly more rapid than quinacrine and the urinary output of SN 7618 may be increased by the acidification of the urine and be decreased by alkalinization.

SN 7618 is concentrated in nucleated cells, especially those of the liver, spleen, kidneys, and lungs, and these organs contain the highest concentrations, from 200 to 500 times the amount in the plasma. The drug is also concentrated to a considerable extent in the leucocytes. The brain and spinal cord contain the lowest concentrations, no more than 10 to 25 times the amount in the plasma. Only a small part of the drug administered is found in the excreta, since SN 7618 like quinacrine is metabolized in the body. Following the administration of the drug, 10 to 20 per cent is excreted unchanged in the urine. These factors necessitate the administration of a priming dose if the desired concentration of the drug in the plasma is to be rapidly reached and maintained. SN 7618 slowly disappears from the body when the dosage is discontinued; the concentration in the body fluids generally falls about 60 per cent per week when drug administration is discontinued.

There is little difference in the toxicity of SN 7618 and that of quinacrine in experimental animals. In man, mild and transient headache, visual disturbances, pruritus, and gastro-intestinal symptoms have followed the administration of SN 7618 adequate for the acute attack. In chronic toxicity studies in man using a dose (0.5 gram weekly) in excess of that necessary for adequate suppression, no serious symptoms, and no impairment of health have been observed in 31 subjects over a period of eleven months of consecutive drug administration. One patient developed a lichen planus-like eruption after eight months of therapy which subsided ten days after discontinuation of the drug. In studying the record of 5,000 individuals who have received SN 7618, no toxic manifestations have been observed that have been constitutionally serious and all have been readily reversible. It does not discolor the skin.

SN 7618 is more active than quinacrine in all of the avian malarias in which it has been tested. It is highly active against the erythrocytic forms of plasmodium vivax and plasmodium falciparum. It does not prevent relapses in vivax malaria even when administered in doses many times that required to terminate an acute attack, nor will it prevent the establishment of vivax infection when administered as a prophylactic. It is highly effective as a suppressive agent in vivax malaria and in terminating the acute attacks of vivax malaria, significantly lengthening the interval between treatment and relapse beyond that observed with quinacrine and quinine. In falciparum malaria it has been demonstrated to suppress the acute attack and to effect a complete cure of the infection. Studies of the antimalarial activity of SN 7618 against well standardized strains of plasmodium vivax and plasmodium falciparum have shown its activity to be approximately three times that of quinacrine. In well tolerated therapeutic doses the majority of patients will be afebrile within 24 hours, and the remainder within 48 hours. Thick smears will generally be negative for parasites within 48 to 72 hours.

For the acute attack, an initial dose of 0.6 gram of SN 7618 followed by an additional 0.3 gram after six to eight hours and a single dose of 0.3 gram on each of two consecutive days

is sufficient to produce prompt disappearance of symptoms and of parasitemia. This procedure will eradicate infection due to plasmodium falciparum and terminates the acute attack of plasmodium vivax infection. In vivax infection freedom from clinical attacks may be maintained thereafter by the administration of weekly doses of 0.3 gram. Satisfactory responses also have been reported following the administration of 1.2 grams in divided doses over a period of 24 hours.

For the suppressive therapy of malaria a single weekly dose of 0.3 gram given on the same day of each week has been found effective.

NEWER RESEARCHES

The exploration of the 8-aminoquinolines has received the major emphasis this past year by the Board for Coordination of Malarial Studies with the hope of uncovering a non-toxic curative agent.[20] It seems reasonably certain that the older investigations of the antimalarial activity of pamaquin led to conclusions which are essentially correct, namely, that when it is administered in high dosage concurrently with quinine over a long period of time, it has a curative action in vivax malaria. Shannon[21] states: "It demonstrates that the persisting tissue forms of the plasmodia which are held to be responsible for the relapse in vivax malaria are subject to the lethal action of a drug to which the type of host cell within which they reside are not also generally susceptible." Marshall[18] states: "It is now practically certain that quinine and pamaquin, under certain conditions, will cure both domestic and Southwest Pacific strains of vivax malaria. However, there is probably not a sufficient margin between minimal curative and maximum tolerated doses to warrant its use at this time." Shortly after pamaquin became available for large scale experimental use it became apparent that the doses recommended earlier could be expected to lead to seriously toxic effects. The toxic effects of pamaquin are increased when given concurrently with quinacrine. The more common symptoms associated with toxicity due to pamaquin are: Cyanosis without dyspnea, pallor, nausea, gastric pain, headache, dizziness, drowsiness, and hemoglobinuria. The most serious toxic hazards are those which occur following intravascular hemolysis and are most likely to appear on the fourth or fifth day.

The Board for the Coordination of Malarial Studies has screened several hundred 8-aminoquinolines in at least one avian infection and, of these, about 50 have been assessed for therapeutic activity in at least two avian infections and two hosts and have been screened for toxicity in the monkey and rat.[18] About twenty of this latter group have been tried for their curative effects in Southwest Pacific vivax malaria. One compound, SN 13,276 8-(5-isopropylaminoamylamino)-6-methoxyquinoline, appears to be curative in a smaller dosage than pamaquin and to be about one-half as toxic for man. Other 8-aminoquinolines are being explored with the hope of developing a drug with the curative action of pamaquin but without its toxicity. However, the final tests for the determination of both activity and toxicity of a new antimalarial drug must be made in man.

D. Paludrine (M 3349) N_1-p-chlor-phenyl-N_5-isopropylbiguanidine. Paludrine is an antimalarial compound prepared in the Laboratory of the Imperial Chemical Industries in Manchester, England. It is a white powder that does not cause yellowish discoloration of the skin. It is rapidly absorbed when given by mouth but is excreted slowly. Studies were made of this preparation under the auspices of the Medical Research Council of England. It is supplied in tablets each containing 0.2 gram. It is readily soluble and has a bitter taste. Its recommended dosage is three tablets (0.6 gram) daily. In England, doses of 1 gram daily were given but with toxic effects.

Das Gupta, et al.,[22] reported on its use in India and they found that paludrine had an antimalarial effect similar to quinine and quinacrine. They stated that the fever due to plasmodium falciparum and plasmodium vivax was promptly controlled and blood smears for malaria became negative. In quartan malaria the antimalarial effect of the drug was poor. The relapse rate of plasmodium vivax was about the same following therapy with paludrine as with quinine and quinacrine therapy. There were no relapses with falciparum malaria. In patients with good general health the toxicity of paludrine was low and was limited chiefly to nausea and vomiting. In patients with complicating diseases, particularly of the respiratory tract, the toxicity of the drug seemed to be increased. Sufficient information has not been released yet to evaluate this drug as an antimalarial.

Another series of compounds which have been extensively studied at least in experimental animals, comprises the quinolinemethanols, which can be considered as being rather closely related to quinine.[18] Ainley and King[23] reported in 1938 the first compound of this series to be found active in avian malaria and this group has been referred to as the A-K series. Later King and Work prepared another series from the quinolinemethanols and found them also to possess antimalarial activity. This latter group has been referred to as the K-W group. About 200 compounds of the quinolinemethanol type have been prepared and in both the A-K and K-W series there are now compounds about 40 times as active as quinine. About five of these compounds

have been tried in man for antimalarial activity and toxicity, but due to poor absorption or toxicity none of these compounds appeared promising enough for further trial. This series is, however, worthy of further study.

IMMMUNITY IN MALARIA

"The mechanism of immunity in malaria is not clearly understood, but it is possible to demonstrate specific protective and complement-fixing antibodies and agglutinins in the serum of experimental animals after recovery from the acute attack.[24] The chief defense of the body against an acute malarial infection, or recovery from a relapse, probably depends upon a greatly accelerated rate of phagocytosis by the individual macrophages of the reticulo-endothelial system." A malarial infection confers a low-grade but specific immunity upon its host after the attack has subsided. This acquired immunity in man is of short duration, as the individual may have repeated attacks produced by the same organism within a relatively short space of time, and in experimental animals the residual immunity following the complete eradication of the infection persists only a few weeks. There is no cross immunity in human malaria, and it was commonly observed in the Southwest Pacific that patients often had a simultaneous infection with two or more types of malaria. The immune response of human subjects to malarial antigen has not shown promise, either in the prevention or modification of the disease or in the production of complement-fixing bodies which might be useful in differentiating between a latent infection and a cure in vivax malaria.[20]

NON-SPECIFIC TREATMENT OF MALARIA

Recently Tumulty, et al.,[25] reported their observations on several thousand soldiers with recurrent attacks of benign malaria in a U. S. general hospital on a non-malarial island in the South Pacific. These men had not been able to return to combat duty because of chronic malarial symptoms and recurrent attacks of malaria despite both active and suppressive treatment with quinacrine. Physical examination did not reveal any significant clinical findings except weight loss in excess of controls and a palpable liver and spleen in a few cases. The characteristic symptomatology in these chronic malarial patients between attacks included weakness or fatigability in 94 per cent, intolerance to heat in 92 per cent, tension in 78 per cent, headache of tension type in 65 per cent, exertional dyspnea in 65 per cent, anorexia in 45 per cent, insomnia in 45 per cent, "blackouts" and palpitation in 40 per cent, and splenic tenderness in 27 per cent. From a correlation of these symptoms with physical condition, personality adjustment, and malaria, the authors concluded that "a considerable portion of the symptoms could be attributed to the recurrent attacks of malaria alone".

The best adjusted and least debilitated patients had relatively few complaints except weakness and fatigability after exercise. The patients who made poor adjustments in civil or military life made poor adjustments to the recurrent attacks and became incapacitated early with a wide variety of symptoms. The authors emphasized that treatment should be directed to the patient as a whole and not to malaria alone. Such measures must include the prevention and control of the debility and poor adjustment conducive to chronic symptoms. A study of the entire reaction of the individual is needed to apply intelligent treatment. Hospitalization should be minimized and the patient should be encouraged to work and to take part in recreation in order to reduce the tendency to the development of neurotic patterns. The Medical Consultants Division of the Surgeon General's Office of the Army[26] stated: "Indeed anxiety and worry over the significance of the relapses may be far worse for the patient than the properly treated disease itself."

Coggeshall[3] in a detailed study of 3,000 patients with malaria segregated at one place in this country, reported that except for a persistent headache in a few individuals there is nothing to indicate that an individual is suffering any discomfort between his acute episodes of fever. Following a short furlough, the patient is placed on full duty status, which includes military training, recreational activities, and educational and vocational exercises. These men were found to gain weight, the red cell count and hemoglobin increases, and there is rapid improvement in their general physical condition. The abuse of rest is very apparent during the convalescent period and there is no doubt that the program designed to keep men occupied mentally and physically during this time is real preventive medicine.

The general practitioner of medicine today who is called upon to treat a patient with chronic relapsing vivax malaria can by the proper administration of antimalarial therapy and by the proper psychological approach restore these individuals to a useful productive life in the community.

SUMMARY AND CONCLUSIONS

1. While the potentiality exists for the spread of malaria in this country, sufficient time has elapsed since the return of thousands of infected military personnel to show that malaria has been held effectively in control.

2. In the State of Ohio, four species of anopheles have been identified, one of which **Anopheles quadrimaculatus**, is capable of transmitting vivax malaria. Adequate mosquito con-

trol methods should be instituted to eliminate this hazard.

3. Vivax malaria contracted by many of our military personnel will constitute the greatest problem from the therapeutic standpoint because of its tendency toward chronicity. There is evidence to show that the Pacific strain or strains of vivax malaria are more virulent than the domestic strain and that it will recur two or three times as often. The chief danger from Pacific malaria is the possibility of new and virulent strains being introduced into this country.

4. The refractiveness of vivax malaria is thought to be due to certain persisting tissue forms which gain entrance into the tissue macrophages following the injection of the sporozoites by the infected mosquito. Following a period of segmentations, sporulations, and reinvasions, new forms of the parasites are produced which are capable of invading, growing, and multiplying in the red blood cells. There is as yet no drug with a wide clinical experience that is non-toxic and which is capable of destroying these tissue forms.

5. Quinine is not likely to be used to any great extent in the future treatment of malaria especially in this country. Its chief use at the present time would be in the treatment of cerebral malaria by intravenous injection, although cases of cerebral malaria are not apt to prove common in this country. Until some of the newer antimalarial drugs are released, quinine could be used in the rare patient who shows idiosyncrasy to quinacrine.

6. Quinacrine, when used properly, is a highly effective antimalarial agent and is superior to quinine in the routine treatment of the malarias. The recommended dosage of quinacrine today with its higher initial doses permits high initial plasma concentrations of the drug, and a better clinical result. Falciparum malaria can be cured in most cases and while the acute relapse of vivax malaria can be eradicated, vivax malaria can not be cured with quinacrine.

7. In acutely ill patients with fulminating falciparum malaria, or in those patients with nausea and vomiting, intramuscular injections of quinacrine are highly effective and high plasma levels of quinacrine are obtained within fifteen minutes after the intramuscular injection.

8. Suppressive therapy is not likely to be required in this area but following periods of months of exposure to malaria effective suppression can be maintained by the daily administration of 0.1 gram of quinacrine.

9. Considering the large number of patients who have received quinacrine over a substantial period of time, toxic reactions of a serious nature have been relatively few.

10. An exploration of the 4-aminoquinoline group has revealed several drugs which appear superior to quinacrine. One of these, SN 7618, has received the most extensive study in both civilian and military establishments.

11. SN 7618 or chloroquine is more active than quinacrine in all of the avian malarias in which it has been tested. It is highly effective against the erythrocytic forms of plasmodium vivax and plasmodium falciparum but will not prevent relapses in vivax malaria. It is highly effective as a suppressive agent in vivax malaria and in terminating the acute attacks of vivax malaria, significantly lengthening the interval between treatment and relapse beyond that observed with quinacrine and quinine. In falciparum malaria it has been demonstrated to suppress the acute attack and to effect a complete cure of the infection. For the suppressive therapy of malaria a single weekly dose of 0.3 gram given on the same day of each week has been found effective.

12. The exploration of the 8-aminoquinolines has received the major emphasis this past year by the Board for the Coordination of Malarial Studies. As a result of certain studies it is now practically certain that quinine and pamaquin will, under certain conditions, cure both the domestic and Southwest Pacific strains of vivax malaria. One compound in this group, SN 13,276, appears to be curative in smaller dosage than pamaquin and to be about one-half as toxic for man. Exploration of other compounds in this group is being continued with the hope of obtaining a drug with the curative action of pamaquin but without its toxicity.

13. Paludrine was developed in England. Reports from India indicate that it has an antimalarial action similar to that of quinine and quinacrine. Clinical response was good in cases of falciparum and vivax malaria but poor with quartan malaria. The relapse rate of plasmodium vivax treated with paludrine was about the same as that treated with quinine and quinacrine.

14. The non-specific treatment of relapsing malaria should be directed towards the patient as a whole. Hospitalization should be minimized and the patient should be encouraged to work and to take part in recreational activities.

15. The proper administration of antimalarial therapy, and the proper psychological approach will restore the patient with chronic relapsing malaria to a useful productive life in the community.

BIBLIOGRAPHY

1. Shookhoff, H. B., and Strax, P.: Malaria Due to Plasmodium Falciparum in New York. New York State J. Med. 45:2425-2426, Nov. 15, 1945.

2. Butler, F. A., and Sapero, J. J.: Postwar Tropical Disease Problems in the United States. South. Med. J. 38: 459-467, July, 1945.

3. Coggeshall, L. T.: Malaria and Filariasis in the

Returning Serviceman. Am. J. Trop. Med. 25:177-184, May, 1945.

4. Heering, R. E., and Harris, P. L.: Department of Health, State of Ohio. Personal Communication.

5. Venard, C. E., Prof. Zoology and Entomology, Ohio State Univ. Personal Communication.

6. Watson, R. B.: Observations on the Transmissibility of Strains of Plasmodium Vivax from Pacific War Areas by Anopheles Quadrimaculatus. Am. J. Trop. Med. 25:315-321, July, 1945.

7. Russell, P. F.: Lessons in Malariology from World War II. Am. J. Trop. Med. 26:5-13, Jan., 1946.

8. Huff, C. G.: Quoted by Shannon, J. A., and Earle, D. P. Jr.: Recent Advances in the Treatment of Malaria. Bull. New York Acad. Med. 21:467-481, Sept., 1945.

9. Symposium on Human Malaria, Washington, Am. Assoc. Advancement of Science, Publication No. 15, 1-398, 1941.

9a. Boyd, M. F.: Infection in the Intermediate Host; Symptomatology, General Considerations, Symposium on Human Malaria (2) 163-182;

9b. Stratman-Thomas, W. K.: Infection in Intermediate Host; Symptomatology; Vivax Malaria. Symposium on Human Malaria (2) 183-189.

9c. Kitchem, S. F.: Infection in Intermediate Host; Symptomatology, Quartan Malaria. Symposium on Human Malaria (2) 190-195.

9d. Kitchem, S. F.: Infection in Intermediate Host; Symptomatology, Falciparum Malaria. Symposium on Human Malaria (2) 196-207.

10. Shannon, J. A., and Earle, D. P. Jr.: Recent Advances in the Treatment of Malaria. Bull. New York Acad. Med. 21:467-481, Sept., 1945.

11. Board for the Coordination of Malarial Studies, National Research Council: Quinacrine Hydrochloride (Atabrine) for Malaria. J.A.M.A. 125:977, Aug. 5, 1944.

12. Shannon, J. A., Earle, D. P. Jr., Brodie, B. B., Taggart, J. V., and Berliner, R. W.: The Pharmacological Basis for the Rational Use of Atabrine in the Treatment of Malaria. J. Pharmacol. and Exper. Therap. 81:307-330, Aug., 1944.

13. Brodie, B. B., and Udenfriend, S.: Estimation of Atabrine in Biological Fluids and Tissues. J. Biol. Chem. 151:299-317, Nov., 1943.

14. Shannon, J. A.: Progress in Antimalarial Therapy. Research Service Third (New York University) Medical Division, Goldwater Memorial Hospital and Department of Medicine, New York University College of Medicine. In Press.

15. Livingood, C. S., and Dieuaide, F. R.: Special Article, Untoward Reactions Attributable to Atabrine. J.A.M.A. 129:1091-1093, Dec. 15, 1945.

16. Bispham, W. H.: Toxic Reactions Following the Use of Atabrine in Malaria. Am. J. Trop. Med. 21:455-459, May, 1941.

17. A study of the Toxicity of Atabrine Dihydrochloride (Quinacrine Hydrochloride) BUMED News Letter 6:1-5, Sept. 14, 1945. By permission of the Bureau of Medicine and Surgery, Navy Department.

18. Marshall, E. K., Jr.: Chemotherapy of Malaria, 1941-45. Department of Pharmacology and Experimental Therapeutics, School of Medicine, The Johns Hopkins University. In Press.

19. Loeb, R. F., Butler, F. A., Clark, W. M., Coatney, G. R., Coggeshall, L. T., Dieuaide, F. R., Dochez, A. R., Hakansson, E. G., Marshall, E. K., Jr., Marvel, C. S., McCoy, O. R., Sapero, J. J., Sebrell, W. H., Shannon, J. A., and Carden, G. A., Jr.: Activity of a New Antimalarial Agent, Chloroquine (SN 7618). J.A.M.A. 130:1069-1070, April 20, 1946.

20. The Board for the Coordination of Malarial Studies, Wartime Research in Malaria. Science, 103:8-9, Jan. 4, 1946.

21. Shannon, J. A.: Chemotherapy in Malaria, Research Service Third (New York University) Medical Division, Goldwater Memorial Hospital and Department of Medicine, New York University College of Medicine. In Press.

22. Das Gupta, B. M., Lowe, J., and Chakravarti, H.: M 3349 (Paludrine) in the Treatment of Human Malaria. Indian Med. Gazette, 80:241-245, Calcutta, May, 1945.

23. Ainley, A. D., and King, H.: Antiplasmodial Action and Chemical Constitution; Some Simple Synthetic Analogues of Quinine and Cinchonine. Proc. Royal Soc. London, sB, 125:60-92, March 3, 1938.

24. Coggeshall, L. T.: In Cecil's Textbook of Medicine, Sixth Ed. W. B. Saunders Company, Philadelphia and London, 374-383, 1943.

25. Tumulty, P. A., Nichols, E., Singewald, M. L., and Lidz, T.: An Investigation of the Effects of Recurrent Malaria. An Organic and Psychological Analysis of 50 Soldiers. Medicine 25:17-75, Feb., 1946.

26. Information Regarding the Effect of Malarial Attacks on the Health of the Individual. The Medical Consultants Division, Surgeon Generals Office. Bull. U.S. Army Med. Department, 4:105-107, July, 1945.

KEEPING UP WITH MEDICINE

INDIA reports over 225,000 cases of smallpox annually.

* * *

THEY are now saying—those who know from experience—that strenuous stretching or sudden jumping from still position or any type of vault exercises should be stricken from the physical educational program of women.

* * *

RECENT studies indicate a close relationship between nutrition, particularly protein nutrition, and the toxemias of pregnancy.

* * *

THE continuation of radiation therapy in heavy dosage, despite the development of a pneumonitis, often undetected, can produce a residual fibrosis.

* * *

THE Russians report that Anti-Reticular Cytotoxic Serum is helpful in the treatment of chronic skin ulcers and does not in any way interfere with the local treatment.

* * *

COMPLETE abstinence from tobacco is just as important in arteriosclerosis obliterans as it is in thrombo-angitis obliterans even though it is not considered so important an etiological agent in the former. There must be no compromise not even one cigarette.

* * *

DERMATOPHYTIDE of the hands commonly begins with the appearance of groups of minute clear vesicles on the sides of the fingers.

* * *

THE traditional use of whiskey in snake bite is dangerous and can only be condemned.

* * *

WHILE wars have never contributed any new discoveries to medicine, often they have given opportunity to apply a certain recent discovery on such a grand scale as to persuade the masses of its value.

* * *

ON the other hand, the evolution of general surgery throughout the ages has been intimately associated with that of the military variety.

* * *

WE have all the facts that we need to make our people strong and healthy. What we need is real education for living and not more research or more surveys.

* * *

MOTOR traffic accidents are still on the increase. We physicians should teach our patients to drive more carefully.—J.F.

The Etiologic Approach to Chronic Urticaria and Angioneurotic Edema

LOUIS E. LIEDER, M. D., and LAZARUS L. PENNOCK, M. D.

SULZBERGER[1] and others have pointed out that the etiologic approach in chronic urticaria and angioneurotic edema is rarely successful and that the determination of the cause of the malady is the exception. With this we fully agree, but it is the purpose of this paper to point out that diligent, painstaking search for the cause is worthwhile and not infrequently profitable.

Recent chemotherapeutic advances[2] in the treatment of chronic urticaria have been found to be temporary and effective only while the drug, benadryl (beta dimethylaminoethyl benzhydryl ether hydrochloride) is being administered. The discovery and elimination of the actual cause of the allergic symptoms alone offers a basis for complete and permanent relief.

In attempting to reach an etiologic diagnosis, the following procedures must be undertaken. First of all, a careful, unhurried chronologic history is essential. It has been our experience that not infrequently the patient himself is alerted by the searching inquiry so that he may later volunteer very helpful information, even though this can not be elicited in the original interview. Not only must an attempt be made to establish a relationship between specific exposures or ingestion of foods or drugs and the occurrence of urticaria, but also the possible relationship between psychic and emotional factors and the urticaria must be considered. The history of drug ingestion should be carefully investigated. The patient frequently must be reminded of headache remedies, laxatives, sedatives, tonics, medicated douches, etc. Exposure to fumes,[3] pollens,[4] and other inhalants,[5,6] must be considered.

The next step is to determine whether or not foods are responsible for the urticaria. This may be accomplished most simply by placing the patient on an elimination diet as suggested by Rowe,[7] consisting of one protein food, one vegetable, tea, sugar, and salt. The patient is given broiled beefsteak for the protein and white potato for the vegetable. Usually we give 200 mg. of ascorbic acid daily during this period of trial elimination diet. In this manner, within seven to ten days, it is possible to decide on the question of food sensitivity as a factor in etiology. In order to be certain that beef, white potato, and tea are not etiologic agents, another protein food such as fish and any other vegetable, usually selected by the patient, is given for one week, or all foods except beef, white potato, and tea are allowed.

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While the elimination diet is being carried out, the patient should be carefully investigated for foci of infection or infestation. Although dental foci appear to be most important, the tonsils, nasal accessory sinuses, gallbladder, prostate, cervix, appendix, and colon must be considered. Stools should be examined carefully for parasites and ova.

Skin testing by the intradermal method is usually done but very rarely has been of any benefit in discovering the cause of chronic urticaria or angioneurotic edema. Very occasionally inhalant factors are found, the avoidance of which seems to aid in the management of these patients. However, the results of skin tests with foods have not been reliable.

Etiologically, then, we may best classify chronic urticaria and angioneurotic edema in the following manner:

1. Drug allergy.
2. Bacterial allergy (focal infection).
3. Physical allergy.
4. Food allergy.
5. Psychogenic.
6. Miscellaneous, including especially:



Fig 1 Angioneurotic edema due to mercury senitivity

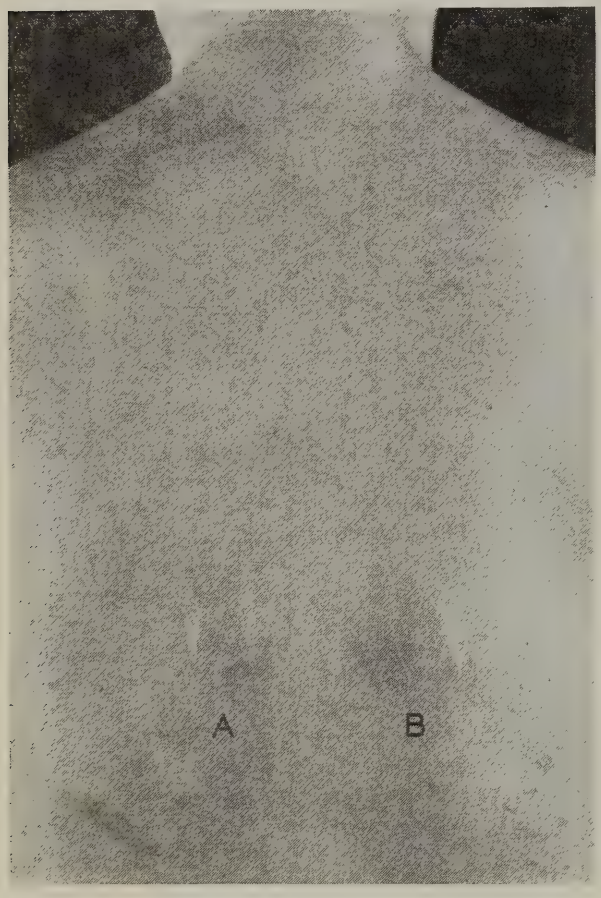


Fig. 2. A. Patch test with 1 per cent yellow oxide of mercury. B. Patch test with 1 per cent mercuric chloride.

a. Inhalants: pollens, silk, dusts, feathers, etc.
b. Parasitic infestations: roundworm, tapeworm, whipworm, hookworm, etc.
c. Systemic diseases, such as brucellosis.
d. Mycotic infections: dermatophytosis, etc.
e. Endocrine disturbances: pregnancy, menstruation, hypothyroidism.
f. Endocrine products: insulin, liver extract, etc.
g. Fumes of paint and drugs and tobacco smoke.

In our experience, drug and bacterial allergy

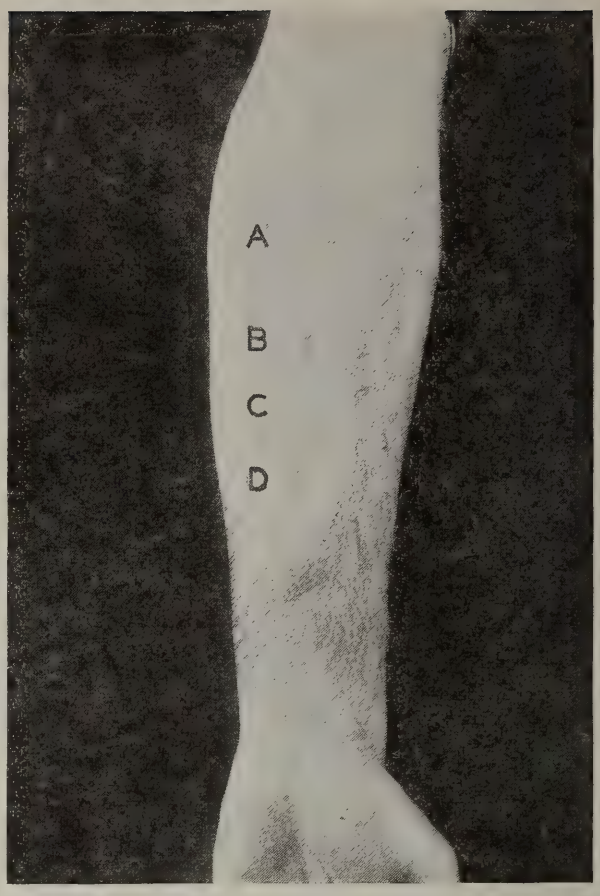


Fig. 3. Patch tests: A. Mercresin 1 per cent; B. Mercurochrome 1 per cent; C. Merthiolate 1 per cent; D. Metaphen 1 per cent.

are far more important than the other categories. Food allergy undoubtedly is most important in the acute urticarias, but extremely rare in the chronic forms. Physical allergy causing urticaria is not infrequent but usually is milder in degree. Psychogenic causes for chronic urticaria are usually difficult to establish and probably occur more frequently than it has been possible to ascertain.

Case reports of chronic urticaria and angioneurotic edema illustrating drug, bacterial, and physical allergy will follow. These cases clearly demonstrate the importance of discovering the causative factors if permanent benefit is to be obtained.

DRUG ALLERGY

Case 1. A 23-year old soldier was admitted to Walter Reed General Hospital on 3 September 1943 by transfer from the Station Hospital, Fort Belvoir, Virginia. He enlisted 25 June 1942. As a civilian he was a machinist. In the army he was assigned to the Infantry.

He was entirely well until 30 December 1942, when he was treated with yellow oxide of mercury ointment for a stye on his left eyelid. By evening his eyelids were swollen shut and his entire face and neck were markedly edematous. He was hospitalized at a station hospital for eleven days at that time. The swelling persisted for a total of three weeks. While in the station hospital, he was patch tested to mercury with a positive reaction. Since that time he had

six to eight attacks of edema of the eyes and has had five hospitalizations at a station hospital.

During one admission, he was treated with one application of 25 per cent mercurial ointment for pediculosis pubis. This caused a severe generalized dermatitis with exfoliation. Because of continued attacks of angioneurotic edema of the eyelids, he was transferred to Walter Reed Hospital for allergic studies.

Family history revealed one sister has chronic urticaria.

Patch tests with 1 per cent yellow oxide of mercury ointment, 1 per cent mercuric chloride, mercury amalgam, tincture mercresin, and tincture metaphen were strongly positive. Mercurochrome gave a slightly positive patch test and merthiolate was negative. Intradermal skin tests were essentially negative except for a pseudopodic reaction to horse serum (Figs. 2 and 3).

Careful inquiry revealed that except for the two severe attacks of dermatitis and edema which followed the application of mercury ointments to the skin, each bout of angioneurotic edema followed a visit to the firing range. It soon became clear that exposure of the soldier to the fumes of mercury fulminate from the exploding detonator caps accounted for his symptoms. Patch tests to numerous other common contact substances, which have been found to be frequent sensitizers, were entirely negative.

This case illustrates one of the many obscure ways in which drugs may be contacted. Markow[8] has shown that mercury amalgam in dental fillings may be the source of absorption of mercury and the cause of clinical symptoms in mercury sensitive individuals.

Case 2. A 36-year old white sergeant was admitted to Walter Reed General Hospital on 2 October 1944 as a transfer from overseas duty. He entered service 11 April 1942 with the Field Artillery. The patient's past history was entirely irrelevant. The family history was negative for allergy.

In November 1943, he developed an upper respiratory infection followed by wheezing, productive cough, and shortness of breath. He had a number of similar attacks, and on 24 April 1944, was hospitalized at a field hospital. He was treated with a sulfonamide and phenobarbital and returned to duty after four days. A few days later he developed a dermatitis of his chest which soon spread to involve the arms, hands, and finally the entire body. He was rehospitalized on 25 May 1944. Treatment with sodium salicylate and phenobarbital caused marked exacerbation of the dermatitis. The skin eruption was characterized by erythema, oozing, and desquamation. On 21 June 1944, he was transferred to a general hospital. While there he was given "sleeping pills" on several occasions with exacerbation of the dermatitis, including exfoliation. On 11 September 1944, he was evacuated to the United States and was admitted to the dermatology section, Walter Reed General Hospital, on 2 October 1944.

Physical examination at the time of admission was entirely negative except for a mild generalized erythema and ichthyosis. Laboratory studies were negative or within normal limits except for a moderate hypochromic anemia and leukocytosis. The vital capacity was reduced approximately fifty per cent.

On the dermatology service, the patient's dermatitis greatly improved with mild emollient medication. On 8 November 1944, following calisthenics, he developed wheezing and shortness of breath. Examination revealed the typical findings of bronchial asthma. Phenobarbital and ephedrine were prescribed. Within four hours, he developed severe generalized itching and marked swelling of the face, urticaria on the trunk and extremities, accentuation of his wheezing and shortness of breath. Within the next week, he developed a generalized erythematous, maculopapular dermatitis, followed by generalized exfoliation. Intermittently he exhibited angioneurotic edema and urticaria while the wheezing in the chest persisted. He was transferred to the allergy service.

By the first of December 1944, the dermatitis had almost completely cleared, leaving only a moderate dryness and scaling. He developed two small abscesses on the left thigh which became confluent and were incised and drained. During this period, he had marked anorexia and on 11 December 1944, a diagnosis of pellagra was made because of an extremely red smooth tongue, fiery-red rectal mucous membranes, diarrhea, and mental confusion. Treatment with nicotinic and ascorbic acids and thiamin chloride was begun. Within a week the evidences of pellagra had subsided and the patient's appetite returned.

He was given ephedrine and sufonamides again cautiously without recurrence of the dermatitis, urticaria, or angioneurotic edema. Intradermal skin testing revealed a few positive reactions to inhalants and foods, especially to cottonseed.

Careful review of the transfer records revealed that each attack of dermatitis with exfoliation, urticaria, and angioneurotic edema had been preceded by the administration of a barbiturate. It was deemed inadvisable, because of the severity of the dermatitis with exfoliation, to readminister a barbiturate to reproduce the symptoms. Five bouts of exfoliative dermatitis after barbiturate therapy seemed to us to be enough evidence of this sensitivity.

This case reveals the severe allergic reactions which may follow small doses of drugs and the protracted symptoms. It seems remarkable that a dose as small as 0.1 gm. (1½ grains) of phenobarbital can cause severe dermatitis, angioneurotic edema, and urticaria for six to eight weeks or longer as it did in this patient.

Case 3. A 39-year old captain developed an erythematous pruritic eruption on the lower anterior part of his neck on 17 August 1944. This was treated with 5 per cent ammoniated mercury ointment, whereupon the eruption spread to involve the entire anterior neck, chin, and lower jaw. He then reported to the dermatology clinic, Walter Reed General Hospital, where Burow's solution compresses and a shake lotion was prescribed. On 25 August 1944, he developed generalized urticaria accompanied by severe pruritus. That night he had giant hives and severe angioneurotic edema of the face, feet, and hands. He was unable to sleep the entire night despite the administration of multiple doses of sedatives and five injections of epinephrine. The hives began to recede the following day and gradually disappeared in the next few days.

He was referred to the allergy clinic where all routine patch tests and intradermal tests were negative. However, a patch test with well-diluted Barbasol which he used in shaving was strongly positive. The patient had been using Barbasol shaving cream for about fifteen years without any difficulty. The dermatitis, however, followed the use of a new jar of cream which,

according to the label, contained 1 per cent sulfathiazole. He was advised to use shaving cream which did not contain sulfathiazole and had no further difficulty. He was also cautioned about taking sulfonamides. Unfortunately, a patch test with sulfathiazole or Barbasol without sulfathiazole was not done.

He remained well until 17 January 1945 when, despite his objections, a physician prescribed sulfadiazine for a sore throat. On that date he took six 0.50 gm. (7½ gr.) tablets. That night his neck became erythematous and began to itch. The area of dermatitis involved exactly the same area as in August, 1944. The next day he had a more generalized eruption, consisting of erythematous papular lesions and urticaria. The site of the patch test to Barbasol containing sulfathiazole on the forearm, which had been done six months previously, became markedly positive again. It was deemed inadvisable to do further patch testing at that time for fear of exacerbation of symptoms. With symptomatic therapy and the forcing of fluids, improvement began in 24 hours and he was entirely clear in a few days.

This case points out the fact that generalized allergic symptoms may follow the local application of drugs. Trans-epidermal absorption takes place readily with many drugs and sensitization may occur. The relighting of the patch test and the recurrence of the eruption first on the neck after ingestion of the drugs, reveals that local sensitization in the tissues persists at least six months and probably a great deal longer as in the fixed eruption of phenolphthalein.

Case 4. A 22-year old white WAC private was seen in the Allergy Clinic on 26 May 1944. For a few months she had had generalized urticaria accompanied by pruritus. Intermittently she had also had swellings of the feet, lips, and eyelids. There was no previous allergic history of any type and the family history was negative for allergy. A careful history elicited the fact that she had been taking Ex-Lax and Feenamint but had not noted any relationship of these drugs to her symptoms. Before other studies were to be carried out, she was advised to stop taking the phenolphthalein laxatives with prompt alleviation of her urticaria and angioneurotic edema. Because she remained free of symptoms, no further studies were carried out and the patient has remained well.

In this patient, allergic symptoms ceased promptly after ingestion of the causative drug was discontinued. However, it is more common, especially in patients with aspirin sensitivity, for the urticaria to persist for many weeks after the drug is stopped. Urticaria following the injection of endocrine products in oil usually persists for a number of months after the last administration.

We have seen numerous patients with urticaria and angioneurotic edema following penicillin therapy. Invariably, however, symptoms are acute in type and clear spontaneously within two weeks after the drug is stopped. The urticaria and angioneurotic edema following penicillin usually exhibits a latent period exactly like that seen in serum sickness. The symptoms occur seven to ten days after the penicillin is started. In patients who have been gven penicillin for only a few days, the urticaria usualy occurs about a week later and the relationship to the administration of penicillin may be overlooked. Individuals who have had previous courses of penicillin therapy are more apt to develop allergic reactions to the drug. We have found that urticaria following a second or subsequent course of penicillin is much more common than with the first course. In patients in whom the continued administration of penicillin is essential despite the occurrence of urticaria, we have continued to give the drug without greatly exacerbating the allergic symptoms. In a few patients the urticaria has disappeared while the drug was continued, although this is not usual.

The use of penicillin in beeswax-peanut oil, as described by Romansky and Rittman,[9] does not increase the occurrence of urticaria and angioneuritic edema. Approximately seventy patch tests with penicillin and penicillin in beeswax-peanut oil and intradermal tests with penicillin were done in patients who have had one or more courses of penicillin or penicillin-beeswax-peanut oil. These tests were entirely negative except for one patient who gave a positive patch test to penicillin itself. An attempt was made to transfer this sensitivity by the Prausnitz-Kustner technic but the skin sensitivity failed to transfer.

BACTERIAL ALLERGY

Case 1. A 27-year old white sergeant was admitted to Walter Reed General Hospital on 10 February 1943 by transfer from a station hospital. The patient gave a history of painful swelling of the hands, wrists, toes, and heels for the past two years every time he "caught cold". His feet would become so swollen that he could not wear his shoes. Each attack usually lasted for three or four days. All of his attacks occurred during the winter months and had followed acute upper respiratory infections.

In February 1942, while in the military service in Missouri, he had a slight cold and some swelling of his feet which cleared within 24 hours. He was then symptoms-free until 2 February 1943. At that time he developed a mild cold and that afternoon noted pain and swelling in the small toe of his left foot. The swelling soon involved the heel of the same foot and later the left hand. By the following morning both hands and feet were markedly swollen and painful and he was hospitalized at the station hospital. The following day he developed edema of the eyelids and giant urticarial wheals over the front and back of his chest. Treatment with epinephrine and ephedrine gave little relief. On the following day, 5 February 1943, edema of the lips developed. He showed gradual improvement until 10 February 1943 when marked swelling of the throat and tongue occurred. He was given two injections of epinephrine without relief and transferred to Walter Reed General Hospital the same day. It was felt at the station hospital that he would shortly require a tracheotomy because of increasing dyspnea due to the oral swelling. The tongue filled the entire oral cavity.

Physical examination on admission was essentially normal except for the markedly swollen tongue which filled his mouth, could not be pro-

truded, interfered markedly with speech, swallowing, and respiration. Epinephrine (minims 5) was given hypodermically on admission and ordered repeated every two hours as long as necessary. He was also given 10 cc. of 10 per cent calcium gluconate intravenously. Ice compresses were applied to the neck.

By evening his tongue was less swollen and he was able to swallow liquids. The next morning urticaria was present on his forearms and his jaws and eyelids were swollen. He was placed on an elimination diet, omitting milk, wheat, egg, chocolate, nuts, and fish. Careful search for foci of infection was instigated. Although no history of drug ingestion was obtained, it was suspected that the patient's allergic reaction might be due to aspirin which he had occasionally taken when he had upper respiratory infections. However, administration of aspirin in the hospital on a number of occasions failed to elicit any allergic reactions. All foods were returned to the diet without producing symptoms. The study for foci revealed the presence of three impacted teeth with pericoronal areas of resorption.

On 23 February 1943, one of his three impacted teeth was removed and was found to be definitely abscessed. Within twenty-four hours he developed edema of the hands, feet, face, lips, eyelids, and tongue, requiring calcium gluconate intravenously with fairly prompt relief, although mild symptoms persisted for ten days. On 13 March 1943, a second infected and impacted tooth was removed and again within twenty-four hours he had angioneurotic edema of the hands and feet requiring intravenous calcium and the use of epinephrine. His last impacted tooth, which clinically was not infected, was removed on 2 April 1943 without causing symptoms. On 6 April 1943, he developed a mild nasopharyngitis and by the folowing morning again had edema of the hands, feet, eyelids, and lips, requiring epinephrine and intravenous calcium. Within four days he was symptom free and has remained so to the present time.

It appears quite definite that foci of infection in his teeth were responsible for his allergic symptoms and that the urticaria and angioneurotic edema also followed acute upper respiratory infections because of his bacterial sensitivity. The dramatic exacerbations of angioneurotic edema following the removal of the dental foci, in our opinion, must be considered as indicative of the causal relationship. Bacteriological studies were not carried out at the time of the dental extractions.

Case 2. A 33-year old white private was admitted to Walter Reed General Hospital on 14 January 1944. He was inducted into the army on 8 January 1944. There was no past history or family history of allergic diseases.

On the evening of 13 January 1944, at his post in Illinois, he first noted marked swelling of his right hand. He had been scrubbing the walls in his barracks the day previously and attributed the swelling to the marked pressure on his hand from the scrubbing. The following day he entrained for a new post in New Jersey. On the train, the right hand became more swollen, very red, with extension of the erythema on the volar aspect of the arm up to the elbow. When his train reached Washington, he was sent to Walter Reed General Hospital with a diagnosis of cellulitis of the right hand with lymphangitis. On admission to the surgical service, it was noted that the swelling involved mainly the second and third fingers of the right hand. There was no lymphadenopathy and his temperature was 99.2 F. orally. The hand and arm were placed in wet dressings and sulfadiazine was started orally. In 48 hours the swelling and erythema of the right hand and arm disappeared but the left hand and forearm then became swollen and red, just as the right hand had done. The appearance of the lesion again closely resembled cellulitis with lymphangitis on the forearm. However, careful inspection of the erythema of the forearm revealed that there was a break in continuity of the redness and it was decided that the entire process was allergic rather than inflammatory in character (Fig. 4).

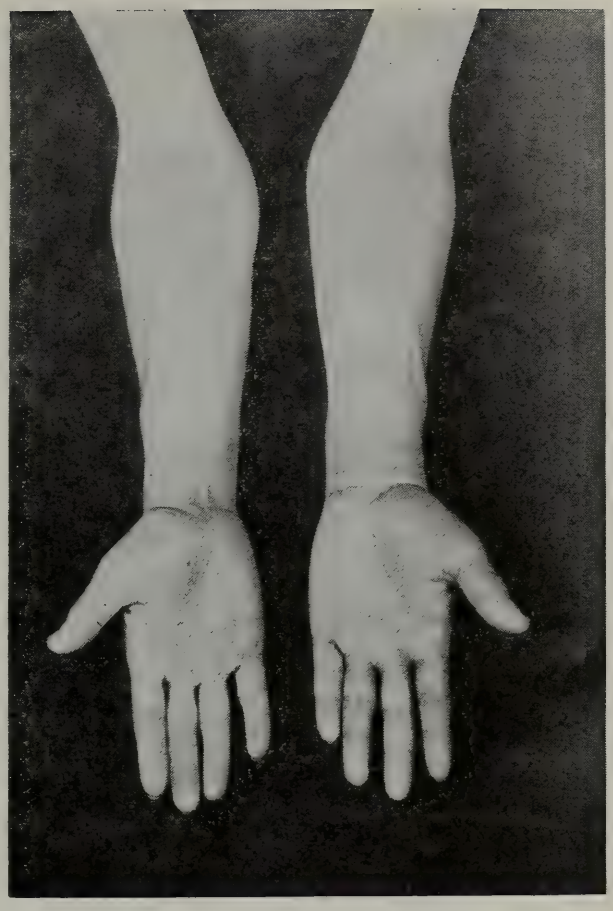


Fig. 4. Note angioneurotic edema of forearms and fingers, resembling cellulitis and lymphangitis.

During the following two weeks, he developed angioneurotic edema of the face, eyelids, feet, trachea, and larynx and urticaria at various pressure points on the body (Figs. 5 and 6).

On a few occasions he had severe substernal pain which was relieved by epinephrine. During these episodes the patient also complained of dysphagia which also cleared following administration of epinephrine. It seemed quite evident that there was allergic edema of the esophagus to account for these symptoms. Careful elimination diets had no apparent effect on his symptoms. No foci of infection could be found. Intradermal skin tests were entirely negative. No history of drug ingestion was elicited.

It appeared that no cause for the patient's allergic symptoms would be found but careful review brought out the information that on 11 January 1944, two days prior to the onset of the allergic symptoms, he had been given his first injection of triple typhoid vaccine. Consequently,



Fig. 5. Marked angioneurotic edema of face.

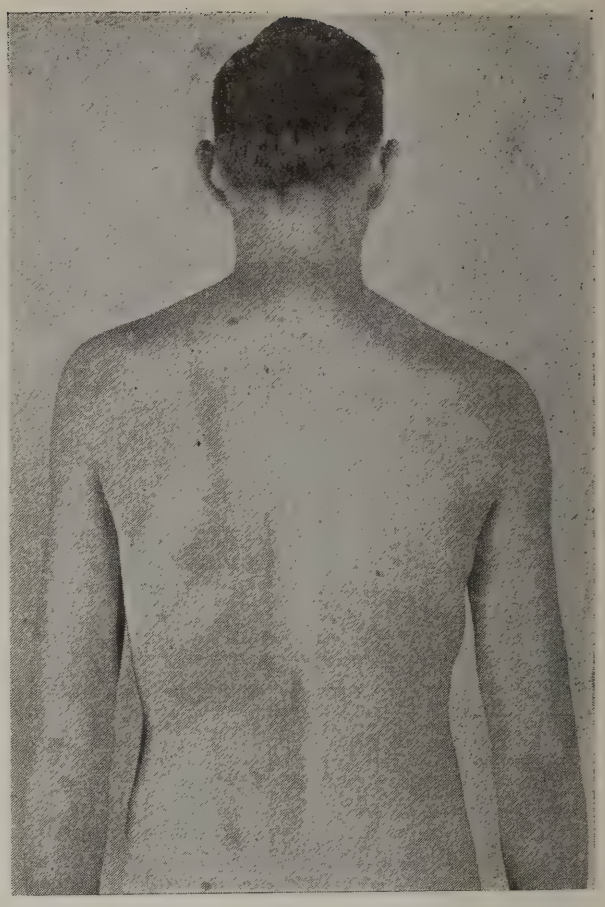


Fig.6. Urticaria and angioneurotic edema of back. most marked below left scapula.

when his urticaria and angioneurotic adema had entirely cleared, he was given a small dose of typhoid vaccine as a trial measure. The next day he again had a recurrence of urticaria and angioneurotic edema. It was deemed advisable to immunize him to typhoid-paratyphoid prior to release from the hospital. Beginning on 14 February 1944, he was started on graduated doses of triple typhoid vaccine. The vaccine was given in daily increasing dosage, well diluted, with intervals of seven days between each course. When the dosage was increased too rapidly, he developed recurrence of symptoms. This seemed to confirm the impression that his allergic symptoms were entirely due to bacterial sensitivity to the typhoid-paratyphoid vaccine.

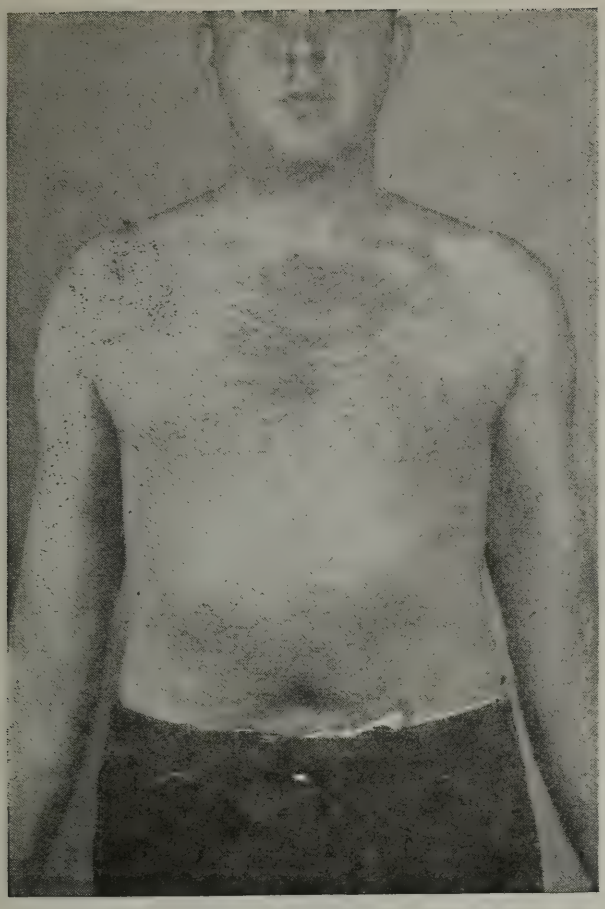
Here we see protracted allergic symptoms after the single administration of a bacterial vaccine. Allergic reactions to vaccines have been very uncommon. In over four years we have seen only three cases of prolonged urticaria attributable to vaccine immunization.

Case 3. A 61-year old general officer was admitted to Walter Reed General Hospital in early April 1943. His only complaint was of generalized urticaria, most marked on the thighs and buttocks and angioneurotic edema of the lips for several months. There was no previous history of urticaria, angioneurotic edema, or other allergic symptoms.

Prior to the onset of the urticaria, the patient had been taking five triple bromide tablets each week and occasionally an aspirin and phenolax tablet. There was no history of ingestion of unusual foods. Examination at a general dispensary prior to hospitalization was negative for foci except that a few pus cells were found in the prostatic secretion.

All previous medications were immediately discontinued and the patient was given trial elimination diets. Symptomatic therapy with epinephrine, ephedrine, and intravenous calcium gluconate was begun. A further search for foci was instituted. These studies were negative except for a definitely cloudy left maxillary sinus by X-ray and transillumination. Because of the pressure of his work and some improvement in symptoms, the patient requested and was allowed to return to duty.

In June 1943, the patient returned to the hospital because of further exacerbation of the urticaria and angioneurotic edema and stated that he had not been entirely free of symptoms since the previous hospitalization. The prostatic secretion was now found to be entirely normal, having been treated by massage during his former admission. The left antrum findings were unchanged. Because the severity of his symptoms interfered with his duties and despite the fact that there were no local evidences of disease in the left antrum, it was deemed advisable to irrigate the sinus. This was done by the otorhinologist although he did not concur in the advisability of carrying out this procedure. The initial irrigation revealed the presence of a small quantity of mucopurulent secretion of mixed bacterial flora. There was a sharp exacerbation in symptoms after this procedure, followed by rapid improvement. After three irrigations on alternate days and the instillation of penicillin, the washings returned clear. Within a week the urticaria and angioneurotic edema



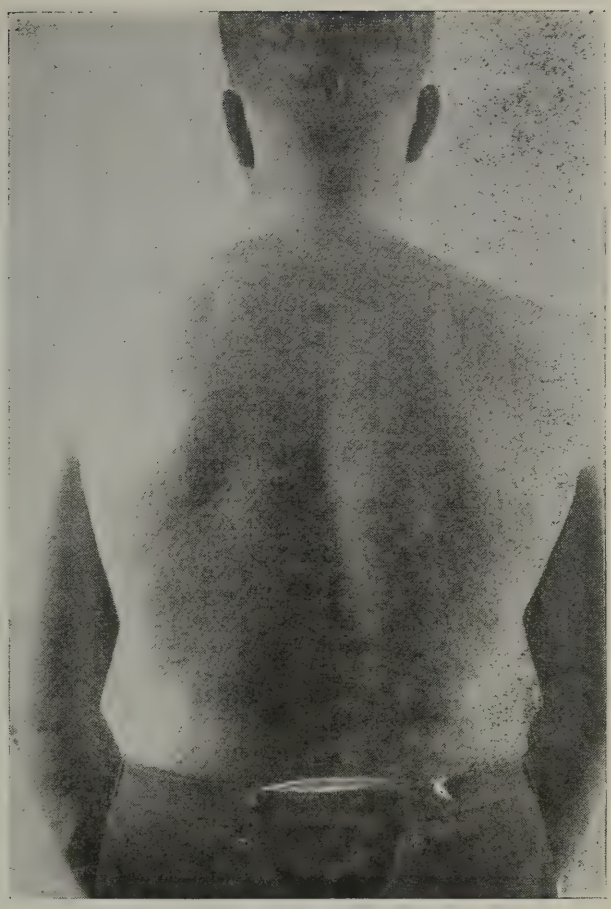


Fig. 7 and Fig. 8. Generalized urticaria after mild exertion (walking for 5 minutes).

had completely disappeared and have not recurred.

Case 4. A 24-year old white civilian dependent was seen in the allergy clinic, Walter Reed General Hospital, in June 1943. Her chief complaint was generalized urticaria of approximately four years' duration. The only significant medical history was that of a chronic endocervicitis of five or six years' duration with accompanying vaginal discharge. Her cervix had been treated almost constantly during this period by various gynecologists in numerous ways without permanent benefit. The cervix had been fulgerated a number of times. Cultures of the cervix revealed the following bacteria: paracolon bacillus, Staphylococcus aureus, and Escherichi coli. A vaccine was prepared using the three organisms. Hyposensitization therapy with the autogenous vaccine was begun with a dilution containing 0.0001 mg. of nitrogen per cc. Treatment was given twice weekly and no other therapy attempted. When a dose of 0.10 cc. of 0.001 mg. of nitrogen per cc. was reached, the patient experienced an exacerbation of hives for a day following the injection. However, after a few doses with only slight increments, this disappeared. The vaccine was continued for three months, using a top dose of 0.35 cc. of the concentrated vaccine containing 0.02 mg. of nitrogen per cc. At the end of the first month of treatment marked improvement was noted and within two more weeks the urticaria had completely abated. Follow-up study for the next two years revealed that there had been no recurrence of the urticaria although from time to time she still had some vaginal discharge.

We realize that there may be a spontaneous amelioration or complete disappearance of urticaria, but the persistence of her symptoms for four years prior to treatment and exacerbations early in the course of her treatment led us to believe that the response was truly a therapeutic one.

PHYSICAL ALLERGY

Case 1. A 22-year old white sergeant was admitted to Walter Reed General Hospital in March 1942. In June 1941, while drilling, the patient for the first time developed pruritic generalized urticaria. The eruption and itching ceased spontaneously with rest in two hours. He has had similar attacks of urticaria appearing on exertion ever since that time. The eruption at times is accompanied by palpitation, tachycardia, and throbbing in the head. During the summer of 1941, the bouts of urticaria recurred two to three times weekly but during the winter of 1941-42, he had been exercising very much less and the attacks occurred only two or three times each month. The patient believed that exertion rather than the heat was responsible for the urticaria. The past history and family history were negative for allergy.

It was soon found that intense generalized urticaria could be reproduced at will at any time by having the patient exercise only moderately. On the ward he was assigned as a tray carrier for bed patients. The act of walking up and down the ward a few times, carrying a tray of food, was sufficient to induce an attack (Figs. 7 and 8).

The urticaria did not respond to epinephrine and subsided spontaneously within forty-five minutes to two hours. Exposure of the trunk to an erythema dose of ultra-violet light failed



Fig. 9. Angioneurotic edema of right hand after immersion in cold water for ten minutes.

to cause urticaria, as did exposure on another occasion to infra-red light.

Laboratory studies were entirely negative except for an extremely low level of vitamin C in the blood. However, there were no clinical evidences of scurvy. Treatment with intramuscular ascorbic acid brought the blood level of vitamin C to normal but failed to influence the production of urticaria on exertion. When his dietary history was checked, it was found that he did not care for and did not eat fruits or vegetables in any substantial quantity.

We have seen an occasional patient with true cold allergy causing angioneurotic edema (Fig. 9).

Urticaria due to heat is quite common but symptoms following exertion are quite rare. It is the second such case we have seen and a third one very similar in all respects was recently observed. Allergy to heat is practically always overlooked because of the brevity of the urticaria but careful inquiry among allergic and nonallergic patients reveals that hives after hot baths and especially hot showers are common. The lesions disappear spontaneously in fifteen to thirty minutes.

In this connection, it is of interest to note that patients will occasionally remark that they sneeze or get hives on first arising in the morning, especially in cool weather. Frequently this is caused by drafts of cold air and can usually be prevented by having the patient put on a pair of warm socks in bed before arising.

SUMMARY

1. The difficulty and necessity of discovering the causative factors in chronic urticaria and angioneurotic edema are pointed out. Permanent benefit to the patient can only be obtained by elimination of the offending allergens or appropriate hyposensitization therapy when the former can not be accomplished. In the psychogenic cases, removal of psychic or emotional stress and strain is of paramount importance.

2. An orderly procedure in the investigation of these patients is outlined. This includes: (a) history; (b) trial of simplified elimination diet; (c) search for foci of infection and infestation; and (d) skin testing.

3. An etiologic classification of chronic urticaria and angioneurotic edema is given. Drug and bacterial allergy (focal infection) play the most important role in causing these allergic manifestations.

4. Case reports illustrating problems in chronic urticaria and angioneurotic edema due to drug, bacterial, and physical allergy are recorded.

BIBLIOGRAPHY

1. Sulzberger, M. B.: Dermatologic Allgery, Springfield, Ill., Charles C. Thomas, p. 493, 1940.
2. O'Leary, P. A., and Farber, E. M.: Benadryl in the Treatment of Urticaria. Proc. of the Staff Meetings of the Mayo Clinic, 20:429, 1945.
3. Gerber, V. J., and Englehardt, H. T.: Urticaria Due to Inhalant Substances, South M. J., 37:12, 729-731, 1944.
4. Taub, S. J., and White, C.: Urticaria Due to Grass Pollen. Jr. Allergy, 2:186, 1930.
5. Sulzberger, M. B., and Vaughan, W. T.: Experiments in Silk Hypersensitivity and the Inhalation of Allergen in Atopic Dermatitis. Jr. Allergy, 5:554, 1934.
6. Rappaport, B. Z., and Hoffman, M. M.: Urticaria Due to Aliphatic Aldehydes. J.A.M.A., 116:2656, 1941.
7. Rowe, A. H.: Elimination Diets and the Patient's Allergies, Philadelphia. Lea and Febiger, 1944.
8. Markow, H.: Urticaria Following Dental Silver (Amalgam) Filling. New York State Jr. Med., 43:1648, 1943.
9. Romansky, M. J., and Rittman, G. E.: Method of Prolonging Action of Penicillin. Science, 100:196-198, 1944.

Pernicious Anemia

In a series of 406 consecutive patients with pernicious anemia: (a) free hydrochloric acid was found in the gastric contents in only one patient, (b) all untreated patients had a macrocytic anemia, (c) the tongue was clean or atrophic in most patients, (d) nearly half complained of paresthesias or difficulty in walking, and (e) in three fourths the vibratory sense was absent.

All symptoms and signs except the achlorhydria are due to a lack of some specific substance normally formed by the interaction of a ferment secreted by the stomach on some constituent of the ingested food and stored in the liver.

The deficiency in idopathic pernicious anemia is permanent, so treatment is required throughout the life of the patient. The object of treatment is to satisfy completely the need for the lacking substance.

A satisfactory method of giving liver extract has been outlined.

Folic acid may prove to be the specific factor needed to supply the deficiency.

Iron, hydrochloric acid, and other medication is seldom needed. A complete diet should be insisted upon.

With adequate therapy (a) the blood returns to normal and remain so, (b) the tongue becomes normal and other gastro-intestinal symptoms such as indigestion and diarrhea disappear, (c) the neurologic symptoms improve or even clear completely, and (d) the achlorhydria is permanent.—Russell L. Haden, M.D., Cleveland; The Journal of the Okla. State Medical Assn., Vol. XXXIX, No. 9, September, 1946.

Cyclopropane Anesthesia; An Evaluation of Ten Years of Experience

A. A. BRINDLEY, M. D.

RETROSPECTION as it is usually indulged in, is a happy pastime and provides one of the opportunities of enjoying again those favorable occurrences which left one content that life is really worth living and that some good had come from it. When combined with introspection, however, and the results set down on paper, the pastime is not quite as happy, but should prove a great deal more profitable. Such an inventory should make one think with Steele that: "My retrospect of life recalls to my view many opportunities of good neglected."

Cyclopropane is described by chemists as the simplest of the cyclic hydrocarbons. The fact that its chemical formula is simple does not necessarily mean that the administration of this gas as an anesthetic agent is also simple. Quite the reverse is true, so true that one may say after 30 years' experience with all types of anesthetic agents, that this gas requires the closest surveillance, the most painstaking care and patience, and intelligent skill in administration.

In the evaluation of any agent or method, the condition under which the agent or method is used must be of necessity taken into consideration. One who works routinely with only two or three surgeons, and those surgeons trained in the same school with their respective technique varying but little, is obviously better able to adopt a routine than one who must change his method with each succeeding anesthetic. It is certainly a definite asset to the patient if the anesthetist can weigh the time, the approximate amount of trauma, and the amount and concentration of anesthetic against the patient's preoperative physical condition.

PREOPERATIVE MEDICATION

In a monograph (Vol. 1, No. 2, *St. Vincent's Hospital Bulletin*) is reported any experience with the use of novatropine in the place of atropine sulphate in preoperative medication. We still use it routinely and the general use of this drug by the other services in our hospital attest to the efficiency of its administration. My conclusions four years ago were:

Novatropine:

1. Is less toxic than atropine sulphate.
2. Does not depress salivory secretions as actively as atrophine sulphate, thereby avoiding intense dryness.
3. Does not induce mydriasis as readily and to as great an extent as atropine sulphate.
4. Does control secretions of the nose, throat, and mouth, thereby maintaining a clear airway and facilitating endotracheal anesthesia.
5. Prevents postoperative nausea.
6. Facilitates gastro-intestinal surgery by elimination of, or markedly reducing, the tone and motility of the gastro-intestinal tract.
7. Aids the control of cardiac arrhythmias induced by cyclopropane, by action on the vagus and control of the vago-vagal reflexes.

ADVANTAGES OF NOVATROPINE

Nothing has happened in the past four years to change these conclusions. Over-enthusiasm may have prompted me to say that novatropine prevented postoperative nausea. I do not think that any drug or combination of drugs will prevent postoperative nausea in every case, regardless of the type of anesthesia or anesthetic drug used. It is my opinion that novatropine greatly reduces the occurrence of cardiac arrhythmia. Cases of circulatory collapse with death have been reported with cyclopropane anesthesia. Such reports have been made with every other type of anesthesia and many such cases occur in previously healthy individuals without anesthesia.

My choice of anesthetic in known cardiac cases is cyclopropane. Waters, in a recent article states, "I personally have not avoided the use of cyclopropane in the presence of circulatory disease." Postoperative circulatory complications occur infrequently after cyclopropane anesthesia.

Other preoperative medication usually consists of phenobarbital gr. 1-1/2, or nembutal gr. 1-1/2

Presented at the Annual Meeting of Ohio Society of Anesthetists, held in conjunction with the Centennial Anniversary Meeting of the Ohio State Medcial Association, Columbus, May 7-9, 1946.

The Author

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or 3/4, the night previous to surgery. Morphine sulphate 1/6 to 1/4 with novatropine, 10 mg. one hour prior to surgery.

During the past four years we have used an increasing amount of hyoscine with morphine especially in large, active, and muscular type of patients. Patients who have an idiosyncrasy to morphine, or patients who express a desire to be asleep before going to surgery, are given pentothal sodium in their room.

CARDINAL PRINCIPLES

There are certain cardinal principles to be observed in the administration of cyclopropane and, while not peculiar to it, are of sufficient importance to permit repetition:

1. The maintenance of an adequate and clear airway. This we do by the use of an oral, nasal, or intratracheal tube depending on the need of the individual patient. Remembering at all times that cyclopropane does not stimulate respiratory effort, normal respiration must be constantly maintained. The margin of safety between a satisfactorily anesthetized thoracic cage and complete respiratory arrest is so narrow that the danger zone of hypoxia may be well entered by the uninitiated and catastrophe result, before realization of the patient's condition is apparent. The use of novatropine (10 gr.) with the preoperative hypodermic will control the secretions of the nose, mouth, and throat, and facilitate the maintenance of a clear airway.

In large, obese patients, severely-ill patients, those on whom particularly difficult surgery is to be performed, we prefer to use endotracheal catheterization before it becomes a necessity. The catheter is passed blindly thru the nose if easily done. If the procedure can not be accomplished readily, we use the laryngoscope and intubate under direct visualization. Patients who fall into this category are those with massive umbilical herniae, large pendulous breasts for radical mastectomy, common duct, and difficult gallbladder cases, thoracic (including diaphragmatic hernia), and all gastric and intestinal cases for whom cyclopropane has been selected.

2. The maintenance of circulatory stability. Any marked variations in pulse rate or blood pressure is an indication of impending surgical shock or the result of continued hemorrhage. Our preference is whole blood, and certainly the greatest single advance in inhalation anesthesia since the discovery of the clinical application of nitrous oxide-oxygen, has been the perfection of the carbon dioxide absorption technique.

FLEXIBILITY

By this method, cyclopropane has gradually become the most flexible and useful of all inhalation anesthetic agents. As with all other methods of anesthesia there are nearly as many modifications of the technique for administering cyclopropane as there are anesthetists. Our technique has varied but little. The bag is approximately half-filled with oxygen (about 2,000 cc. more than enough for tidal exchange). Cyclopropane is started at the rate of 1,000 cc. per minute; oxygen at 200 cc. per minute. When the bag is filled, usually in about two minutes, the cyclopropane is turned off, both at the flowmeter and at the tank. In a large percentage of instances this will have carried the average patient to the first plane of surgical anesthesia.

During this time, the patient will have been prepared for surgery. Cyclopropane is added as, and when, necessary at the rate of 200 cc. per minute. The oxygen flow is continued at 200 cc. per minute during the operative procedure. This amount we have found to be the nearest to an exact statement that one can make about the clinical administration of cyclopropane. Each patient is a clinical entity and must be treated as such. One can no more prescribe the exact amounts of cyclopropane and oxygen for a given patient than one can pre-determine the amount of digitalis necessary for complete digitalization. One learns by experience only the average amounts necessary for a certain procedure under given circumstances; one may follow the book only to the point at which the patient refuses to behave as the book says he should. From that point, the patient's safety and the quality of the anesthesia depend entirely on the attending anesthetist. Success or failure are in direct ratio to skill, patience, and good sense exhibited by the anesthetist. Controlled respiration should be used only for a definite purpose. When an operative procedure demands extreme relaxation and absolute lack of respiratory effort then and then only is controlled respiration indicated.

TRANSFUSIONS

Patients designated as critical or on whom difficult major surgery is to be performed are previously cross-matched and have blood available. We prefer to start transfusion early, anticipating the need, rather than to wait for a failing heart and falling blood pressure to demand emergency treatment. This procedure has paid big dividends in postoperative recovery and convalescence.

The critical shortage of nursing personnel during the war years taught us some invaluable lessons about immediate postoperative care of deeply anesthetized patients, whatever the anesthetic agents. Patients sent back to their room with an inexperienced pupil nurse or nurse's aid, and left to be watched by the same inexperienced people, were frequently the subject of great alarm. Many times I have been called to the floor by an anxious supervisor reporting

that a patient just operated, refused to breathe, or had a poor pulse, no blood pressure, or was cyanotic. Several near catastrophies with patients suffering from varying degrees of anoxemia taught us that the most common difficulty was from a lack of a free airway in patients who had received their preoperative sedative only a short time prior to surgery. Deep surgical anesthesia, if only for a short period of time, plus the full physiologic action of the sedative so depressed their respiratory effort that active resuscitatory efforts were necessary to revive these patients. For the past four years we have been endeavoring to have our patients as nearly awake as possible when leaving the operating table. Immediately following peritoneal closure we switch to a 50-50 nitrous oxide-oxygen mixture which is continued until time to place the patient on the stretcher. Then this mixture is washed out with 100 per cent oxygen.

All patients in whom the gag reflex is not present are sent to their beds wearing an oral airway, which must be functioning satisfactorily. This, plus the fact that all our patients are routinely inflated hourly for eight hours, has eliminated entirely the occasional case of so-called secondary cyclopropane shock.

CURARE

In a very few instances curare has been used for additional relaxation. This procedure—using intocostrin, 40 to 60 units intravenously—has been especially useful in malnourished patients with very acute abdomens, and stocky, obese patients presenting large abdominal tumors. Our experience has not been great, but has been extremely satisfactory. The combination of cyclopropane with spinal anesthesia has been particularly satisfactory in apprehensive individuals who prefer not to be awake during surgery. Many patients are extremely sensitive to the operating room conversation, are prone to react unfavorably to the intravenous administration of fluids or blood, or are startled unnecessarily by the noise of the suction pump. The psychic shock of ordinary operating room procedure to the fearful patient is sometimes greater than the combined shock of surgery and anesthesia. It is the anesthetist's duty to prevent this type of shock, where possible, and in many instances this can well be done by combining cyclopropane with spinal anesthesia. The combination of cyclopropane-oxygen with spinal anesthesia does more than complement the spinal anesthesia. It gives to the patient oxygen, vitally needed, especially if necessary to carry spinal anesthesia to a high level.

Technical variations of methods used depend upon ability, temperament, time element, and everyday likes and dislikes, of the anesthetist. In our early experience with cyclopropane we looked with askance upon it when confronted with a patient having heart disease. Now we use it as the anesthetic of choice in all cardiac cases. Age no longer presents any barrier to its use, our youngest being five weeks and our oldest one hundred and one. Cyclopropane shows no predisposition for either sex, performing equally well with males and females.

The following quotation from Robbins is still appliable and well worth repeating. "It is the combination of potency, rapidity of action, lack of irritation to the respiratory tract, and high oxygen content that makes cyclopropane-oxygen of special value in certain conditions."

These conditions are:

1. Short operations where relaxation is needed.
2. Operations where excess oxygen is needed.
   - A. Due to mechanical causes.
     - a. Obstruction in respiratory tract.
     - b. Reduction in alveolar bed.
   - B. Increased oxygen usage.
     - a. Hyperthyroidism.
     - b. Pregnancy.
   - C. Anemias.
3. Cardiovascular disease.
4. Severe operative risks.

If one is a disciple of Robbins one can believe that cyclopropane is the anesthetic of choice in practically every surgical case except in the presence of an open flame or electrical equipment which might cause an explosion.

THE ALCOHOLIC

There is one other type of patient who will give the anesthetist no end of difficulty in the administration of cyclopropane. The chronic alcoholic is not a good risk for any kind of anesthesia and in my experience this is particularly true with cyclopropane.

The following interesting statistics have been collected in a review of 1,000 consecutive operations performed under cyclopropane anesthesia. All of the operations except 43 have been performed by the same surgeon and all the anesthetics administered by the essayist. The most remarkable fact disclosed in this survey is the very marked reduction in the number of postoperative complications from all causes in this series.

Emesis, first three hours postoperative: Sixty patients, or 6 per cent vomited once or more than once during the three hours immediately following surgery.

Emesis, after six hours postoperative: Fifty-

four patients, or 5.5 per cent vomited during the second three-hour period.

Nausea occurred in 18 patients, or 1.8 per cent in the first three-hour period.

Surgical shock, described as mild, occurred in 5 cases, or .5 per cent.

Bronchitis and bronchopneumonia occurred in 11 cases, 1.1 per cent. All of these patients were symptom-free in 5 days postoperative.

Cystitis occurred in 6 patients, .6 per cent, of whom only one was febrile.

Resuscitation was necessary in only 2 patients; one, an elderly female, who was evidently too well sedated; the other, a young man who was wide awake when I reached him, after two or three breaths of oxygen administrated by the nurse.

COMPREHENSIVE PROGRAM

It is very evident that these results are not all the product of anesthesia. Better preoperative care, better surgery, better postoperative care, the sulfonamides, penicillin, the blood bank and its early use, bronchoscopy—all these things plus better doctors are responsible for the lower morbidity and mortality rates in surgery. Anesthesia has done its part and the future has much in store for better anesthesia. May we continue to supply it.

BIBLIOGRAPHY

1. Steel: Spectator, 374.
2. Brindley: St. Vincent's Hosp. Bull. Vol. 1, No. 2, Apr. 30, 1942.
3. Waters, R. M.: Surgery, 18, 26-32, July, 1945.
4. Robins: Cyclopropane Anesthesia. Williams & Wilkins, Page 146, 1940.

Use of Drugs in Cardiovascular Disease

The nitrates are still drugs of great value for the anginal attack. They are of questionable usefulness, however, and may even be harmful, in attacks of so-called coronary insufficiency. The prolonged pain and various degrees of circulatory collapse associated with acute attacks of coronary insufficiency may require administration of opiates for relief. However, prompt response frequently is obtained by administration of a high concentration of oxygen, or whiskey, or both.

The purine drugs are widely used on the assumption that they increase blood flow in the coronary arteries, but their actual value in the continuous treatment of sclerosis of the coronary arteries is still debatable. Since the preponderance of evidence is in their favor, they probably should be used unless and until more knowledge shows them to be of small value.

Lerman and White recently have reported beneficial effects from the administration of small doses of preparations of thyroid to twenty-one patients.—C. T. Chamberlain, M.D., Ft. Smith, Ark.; The Journal of the Ark. Med. Society, Vol. XLIII, No. 4, September, 1946.

Anesthetic Progress

It is obviously impossible that perfection should obtain when so many factors are variable. It is our job to so administer the agents we have so that the patient is brought through that state of suspended animation with the least appreciable damage to the physiological function. The fact that the patient regains consciousness and reflexes is not sufficient to absolve ourselves from further concern. Anoxia and other latent complications are still our responsibility and must be met. The effects of metabolism in health and disease are variable; retention, absorption, and elimination are disarrayed and only to the experienced observer are the least changes manifest.

Accident cases offer a great problem and contribute largely to anesthetic complications. It is seldom that the emergency is so dire on the patient's part that proper time can not be taken for adequate surgical or anesthetic preparation. Pulmonary complications, asphyxia, anoxia, and in many cases shock, could be averted by proper preparation, and factors which contribute to complications could be eliminated. The day has come when the anesthetist must be regarded as a vital link in the surgical team. Proper teamwork, adequate preparation of the patient, whether it be by narcosis or fluids, and the selection and skillful use of the proper anesthetic agent are necessary for the successful outcome of the procedure.

In the evaluation of an operative risk, taking into consideration the operative procedure contemplated, and the age incidence, the patient may be classed as follows:

Class 1—An individual suffering from no organic disease or with a localized disease causing no systemic disturbance.

Class 2—An individual suffering from disease causing moderate systemic disturbance.

Class 3—A patient suffering from pathological conditions causing severe systemic disturbance.

Class 4—A patient suffering from systemic disorders which are in themselves a threat to life.

Class 5—Moribund patients.

It is necessary that one be familiar with the disturbances in the operating room, a knowledge gained by association and experience and not from a library. One should possess the knowledge and ability to institute necessary measures as occasion demands before being trusted to watch over the fate of life, death, and morbidity. No longer can we content ourselves with that form of anesthesia which simply renders the patient insensible to pain during the surgical procedure. We must maintain the patient's vitality and physiological balance, reducing the effects of shock so that convalescence will be as comfortable as possible.—John M. Whitehead, M.D., Indianapolis; The Journal of the Ind. State Medical Assn., Vol. 39, No. 9, September, 1946.

The Use of a Pessary as An Adjunct to Early Rising in the Puerperium

CHARLES W. PAVEY, M.D.

OBSTETRICS has always regarded arch conservatism as a high virtue, but necessity has given impetus to a change in one of the time-hallowed features of firmly entrenched obstetrical philosophy that should have long ago, and for better reason, sprung from ordinary common sense.

For several years now there has been a gradually increasing tendency to get surgical patients up earlier and little by little we have been hearing more and more on the abuse of bed rest in a variety of medical ailments in which prolonged and absolute inactivity were considered indispensable adjuncts of treatment. In obstetrics, however, the idea has been slow to catch on despite the fact that most of the advantages claimed for early rising would appear to make it extraordinarily desirable during the puerperium.

TRADITION

It is true that there have been a few sporadic case reports in the literature from time to time for many years, but the idea has not been pursued, it has never found its way into obstetrical texts and women have continued to rest themselves into a state of exhaustion. As long ago as 1922, I recall reading an article in a South African medical journal in which the writer advocated early rising in the puerperium based on his own rather limited experience, for the most part among native women. I recall thinking at the time that perhaps what worked well with African native women might be disastrous for white Americans and with that I tucked the item away in a seldom-used recess of my memory for possible later use. This writer, in common with the few more recent and mostly foreign authors, took the somewhat negative attitude that he had managed to accomplish this feat without dire results.

In July, 1944, Rotstein of Baltimore reported about 150 cases and mentioned a series of 3,400 cases in Alameda County, California, in which patients had been allowed to go home several days earlier than usual without untoward consequences providing they satisfied certain criteria. In the year book for 1943, Greenhill observed that he had made a practice of getting patients up on the 5th or 6th day and had had no cause for regret. As a general thing it was the scarcity of obstetrical beds that motivated such trials and the more rapid turnover was considered well up in the list of advantages. While those that have given the method a trial all seem agreed that the patients did better on early rising, there still seems to be a carry over of the defensive attitude that in any case it did no harm.

The necessity for a more rapid turnover of obstetric beds is one of the poorest possible reasons for early rising, but I hope to be able to show you that the procedure is sound, logical and reasonable, and an unquestionable improvement over the obsolete method of the past.

The stock objections usually raised fall into six simple categories: Danger of prolapse, perineal wound disruption, rectocele and cystocele, uterine misplacements, hemorrhage, and embolus.

ROUTINE LOW FORCEPS

There is a certain delivery routine that we feel lends itself particularly to this technique and we use it consistently, and recommend it, although we feel that all features of it are not indispensable to early rising. First of all, we advocate almost the routine use of low forceps and median episiotomy. We feel that this conserves the mother's strength and energy and leaves her in better condition to begin her puerperium. Excessive ironing out of the perineum either by the hand or the baby's head, while it may permit of delivery without demonstrable lacerations, we believe causes irreparable stretching and subcuticular lacerations that either do not heal well or cause excessive scars and loss of support. The use of forceps shortens and greatly facilitates the process of delivery and lends itself readily to delivery under anesthesia which is essential for episiotomy. Median episiotomy is chosen rather than medio-lateral because it is easier repaired, heals better and without scar, and lends itself to the use of the pessary which is routine. For breech deliveries the same technique is used with forceps on the aftercoming head.

Repair is made with a continuous suture of

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triple-O catgut starting at the apex of the wound, inside the vagina, and closing it in successive layers down and back and down again, winding up with a subcuticular which insures perfect apposition and finally either a mattress or over and over stitch which prevents granulations from coming up between the skin margins. The placenta is expressed by gentle crede, ergotrate given intravenously, and then while the uterus is held in place, a Smith-Hodge pessary of suitable size is put in the vagina to hold the uterus in proper position. In the presence of extensive sulcus tears no pessary is used.

After the patient is returned to her room, at the earliest convenient time, normally not less than 4 hours nor more than 14 hours following delivery, she is propped up erect in bed for 15 minutes or longer after which she gets up, on a footstool at first, and then down, standing on the floor from two to five minutes and then back to bed. It is suggested that patients wear an ordinary two-way stretch girdle when getting up and even while lying in bed but doing so is optional. It is a good plan, if possible, to have two nurses with the patient for a few minutes when she gets up for the first time. These patients getting up for the first time on the day of delivery seem to be about as apt to faint, or perhaps a little less so, than patients getting up for the first time on the 10th or 12th day.

In our series, two patients fainted on the first day and one on the fourth. In each instance they felt faint and settled down to the floor gently and without any harm whatever. As a rule, if they get up for the first time in the morning, they will be up in a chair for 15 to 30 minutes later the same day. On the second day they are up at least three times, walking about the room, and by the third or fourth day they are apt to be found anywhere in the hospital except their own bed. Ordinarily they are discharged on the 7th or 8th day with very little restriction on their activity.

THE ANATOMY

The uterus is supported and held in place by a series of ligaments which for the most part are little more than a double fold of peritoneum and a small amount of connective tissue. These ligaments which seem to have been designed to hold the uterus only in the non-pregnant state, are all attached low in the pelvis so that as the pregnant uterus enlarges upward into the abdominal cavity the ligaments are greatly stretched and become temporarily almost useless in the early part of the puerperium by virtue of the simple fact that their length is greater than the distance between their points of normal attachment. They continue to be functionless until they have undergone involution sufficient to restore them to a useful degree of tension. If they are relieved of all tension or stretching it seems logical to believe that involution or shortening of the ligaments will proceed quicker and more fully than if they are maintained under tension. With the patient supine, the oversized puerperal uterus tends to slide back toward one flank putting the ligaments under some tension. With the patient erect, the ligaments are not only under no tension but the improved drainage promotes prompter involution of the uterus as well. Better drainage has the further advantage of minimizing stagnation of lochia and opportunity for infection; and the position of the uterus with the fundus pointing forward and the body of the uterus lying low over the bladder is, of course, the same as the position into which it is pulled to minimize or control post partum hemorrhage. The pessary provides a further safeguard against either prolapse or malposition.

By using the median episiotomy, the soft tissue diameters at the outlet are increased sufficiently that there will rarely be the invisible disruption of fascia that permits the herniation of rectum or bladder. The continuity of tissue is restored by the method of suturing described and for all practical purposes we feel that following repair the tissues are as strong as before. As the catgut weakens progressively by absorption it is compensated by healing and actually in the average ordinary episiotomy there is little, if any, more tension on the wound with the patient erect than when she is supine.

As for embolus, it is now quite generally recognized that inactivity is a leading cause of thrombophlebitis. Activity keeps up the circulation and where there is no circulatory stagnation there is much less risk of thrombus formation and if there are no thrombi there are no emboli.

THE FIRST YEAR

In the first year of this trial, we carried out the procedure with 366 private patients of whom 204 were multiparae and 162 primiparae. Of these, 233 were fitted with pessaries. Only 3 patients declined to give the method a trial. With one exception, the multiparous women, all of whom have now tried both methods, have avowed their preference for early rising. Of the primiparous patients, only one indicated some doubt as to whether she had chosen the wiser course.

Both of these patients on postpartum examination were found to be in ideal condition. The multiparous patient's complaint was that she was subject to dizzy spells which almost certainly bear no relation, whatever, to anything in connection with her pregnancy and are probably due to auto-intoxication. She was one of the nurses in the series. The dissatisfied primipara, a neurotic sort of girl, had no com-

plaint beyond saying she didn't feel as good as she thought she would.

There was one case of mild thrombophlebitis in a doctor's wife which, however, did not appear until the 10th day. Inasmuch as the patient would normally have been up at this time it can scarcely be attributed to early rising; on the other hand it must be admitted that early rising in this instance failed to prevent it. Three patients required secondary repairs although all were superficial and two of them required only skin closure.

On instituting the series we anticipated that it might require some urging in order to get patients to try such a revolutionary procedure. We also anticipated serious difficulty with the patients' mothers and mothers-in-law. Both of these difficulties failed to materialize. The older generation seemingly had been privately and secretly nursing the suspicion all along that there was too much lying abed in connection with childbirth or else they reasoned, considering the gynecological casualties among their friends, that any new method could scarcely produce worse results than the old.

As for the patients, themselves, no one was urged to get up. They were simply offered the opportunity and made their own decision. We were fortunate in that our first patient was both a nurse and a doctor's wife. A girl of uncommon good sense and level headedness and relatively unemotional, she was enthusiastic about giving the method a trial. Accordingly, she got out of bed about 3 hours after a low forceps, median episiotomy delivery. Asked how she felt, she replied that she felt just the same as she did on getting up any other morning. The next day when I arrived to make rounds, she was standing near the elevator far from her room chatting with friends, and a short while later I found her making her bed. From that day on she was hospitalized in theory only.

After that, whenever we had a patient who was undecided about getting up we would have a girl who had delivered a few days earlier stroll in and give her a pep talk. This procedure was a failure in only 3 instances.

THE MATERIAL

As evidence that this series represents a discriminating and critical group, we should like to offer the following rather interesting statistics. The group included 2 doctors, one of whom gave birth to twins that she took to New York with her when 7 days old. There were the wives of 25 doctors and 4 veterinarians, at least 16 nurses and the daughters or sisters of 10 doctors; 28 cesareans, 4 sets of twins, 9 breeches, 2 puerperal sterilizations, 1 deaf mute, 3 perineorraphies immediately postpartum including one operation for rectal fistula. There was only one version and extraction. One patient had a virus pneumonia at the time of delivery and another had an ulcerative colitis that caused from 25 to 40 bowel movements a day. Of the 133 patients that did not have pessaries put in at delivery, 7 later required them, a substantially smaller number than was ever the case with patients kept in bed and of those that had pessaries, only 2 were found to have retrodisplacements at postpartum examination. In both of these, the pessaries had become dislodged.

There is a tendency to put in too large a pessary due to relaxation and anesthesia at the time of delivery. As a result of this tendency on two occasions I was obliged to cut a pessary in order to remove it without undue pain. For this purpose I used a pair of ordinary pruning shears which seemed about ideal for the purpose. We should again like to mention that no pessary is used in the presence of sulcus tears since they tend to cause pain by pressing directly against the wound.

A WARNING

In closing, we should like to offer a suggestion and a warning. Give this method a trial, but if you don't try it, don't be too unequivocal in your statements to your patients opposing it because we predict that you'll be doing it ultimately and the less you say against it now, the fewer words you'll have to eat later on.

BIBLIOGRAPHY

1. Collazo, A. G.: Premature Rising and Gymnastics in the Puerperium. Prensa Med. Argent. 18:1637, May 10, 1932.
2. Atlee, H. B.: Evidence in Favor of a More Active Puerperium. Study of 500 Cases. Canad. M. J., 33:144-140, Aug., 1935.
3. Goralick, R. A.: Early Rising After Labor. Radyanska Meditsina, (Ukranian) 5:65-69, 1940.
4. Stanca, C.: When Shall the Puerperal Woman leave Her Bed? Wien. Med. Wchnschr., 90:176-180, March 9, 1940. (Rumanian) Abstract from the Yearbook of Obstetrics and Gynecology, 1940, Page 245.
5. Ricci, G., and Pla, P. C.: Early Rising in Obstetrics. Bols. Soc. de obst. y ginec. de Buenos Aires, 20:579-592, Nov. 12, 1941. Abstract from Yearbook of Obst. and Gyn. of 1942, page 265.
6. Vara, P.: Early Rising After Delivery. Acta obst. et gynec. Scandinav., 21:168-179, 1941.
7. Armand, M. F.: Early Rising. Obst. y gineco latino-am., 1:688-697, Dec., 1943.
8. Black, B. W.: Do Normal Maternity Cases Require Ten Days in the Hospital? Mod. Hosp., 60:52-53, Feb., 1943.
9. Greenhill, J. P.: As an Editor's Note in Yearbook of Obst. and Gyn. following an article "Duration of Hospital Care in Normal Maternity Cases", 1943, p. 305.
10. Jorge, C. F.: Early Rising in Obstetrics and Service of Home Obstetrical Care. Rev. de ginec. e d'obst., 2:288-291. November, 1943.
11. Daley, A.: J.A.M.A., 126:588-589, Oct. 28, 1944.
12. Acosta, F. P.: Early Rising After Childbirth. Rev. Med. quir. de Oriente, 5:220-226, Dec., 1944.
13. Rotstein, M. L.: Early Rising in Puerperium. J.A.M.A. 125:838-840, July 22, 1944.
14. Guerriero, W. F.: Am. Jr. Obst. and Gyn., 46:312, 1943.
15. An Annotation in Lancet, Vol. 247, p. 509, Oct. 14, 1944.
16. Rosenblum, G., Melinkoff, E., and Fist, J. S.: Early Rising in the Puerperium. J.A.M.A., 129: 13:849. Nov. 24, 1945.
17. Guerriero, W. F.: Early Controlled Ambulation in the Puerperium. American Jr. of Obst. and Gyn., 51:2:210-212, Feb., 1946.
18. Steinheart, P. F.: A Clinical Study of Eary Postoperative Ambulation in Gynecology. Surgery, Gynec. and Obst., 82:3:348-355, March, 1946.

Volvulus of Ileum with Intertwining Loops and Knot Formation

CHARLES S. BECKER, M. D.

This 70-year old negro male had been treated in the Out-Patient Department of Lakeside Hospital for approximately five years for arteriosclerotic and hypertensive cardiovascular disease with mild cardiac failure. The blood pressure had ranged consistently between 180 and 200 systolic and 110 and 120 diastolic. His symptoms had been fairly well controlled with digitalis and symptomatic therapy. Forty-eight hours before admission he developed mild abdominal discomfort and hiccoughs. Twenty-four hours before admission he vomited twice and had a normal bowel movement. His symptoms persisted and he was admitted to the medical service.

He did not seem to be acutely or seriously ill. Significant observations on physical examination included blood pressure 120/90, pulse 90, respirations 20, inconstant rales at bases of both lungs, the left border of cardiac dullness in the midaxillary line and a soft blowing systolic murmur at the apex which was not transmitted. The abdomen was slightly distended and slightly tender. No organs or masses were palpated in the abdomen. The rectal examination was not remarkable. Admission blood count: red blood cells 5,120,000, hemglobin 98 per cent, white blood cells 7,910 with a normal differential count. No urine examination was done because the patient did not void during his brief hospital course. An electrocardiogram was reported as showing a digitalis effect.

During his hospital stay he spat up small amounts of black material. He rested comfortably flat in bed and had no complaints; however, it was noted by one observer that he "seemed quite apprehensive". Six hours after admission he was found dead in bed with approximately 500 cc. of black liquid which was benzidine positive on the bed.

Autopsy (9182). The abdomen contained 600 cc. of clear dark red fluid having a specific gravity of 1.030. A long segment of dilated dark red small intestine arranged transversely in a "step-ladder" fashion occupied the lower abdominal quadrants. The esophagus, stomach, duodenum, pancreas, and biliary system were not remarkable. The first 320 cm. of small intestine beyond the ligament of Treitz was covered by a smooth and glistening serosa, and had walls of average thickness and a normal mucosa. This segment was dilated, having a maximum diameter of 9 cm. At a distance, 320 cm. beyond the ligament of Treitz, two loops of ileum were twisted on the mesentery and intertwined to produce a "bow-knot" as is schematically shown in Fig. 1.

The volvulus affected 120 cm. of the length of the gut. This segment was dark purplish-red in color and the serosa although smooth showed many strands of loosely attached fibrin. The wall of the intestine was of average thickness, dark red and not friable. Except for the dark red color the mucosa was essentially normal and the lumen contained dark red turbid fluid. Microscopically, the involved segments showed acute fibrinous peritonitis together with necrosis of muscularis and mucosa. Distal to segment of volvulus, the gut was covered by a smooth, pale gray, slightly thickened serosa. The walls were not remarkable and the lumen was empty. In one segment, 20 cm. long, several collapsed loops of bowel were adherent to adjacent loops by thick bands of fibrous connective tissue so as to produce a mass approximately 7 cm. in diameter. There were large bilateral indirect inguinal herniae.

The mesentery was markedly redundant. The average distance from the root of the mesentery to the bowel was 15 cm. The root of the mesentery was longer than expected.

The right lung weighed 680 grams, the left 640. They were dark bluish-red, with reduced crepitation in all lobes. The lungs sectioned with slightly increased resistance to reveal smooth, exceedingly wet, slightly bulging, bluish-red, freely bleeding cross section, uniform in all lobes.

Significant pathological diagnoses: Acute volvulus of lieum with knot formation; acute hemorrhagic necrosis and intestinal obstruction; acute serofibrinous peritonitis (600 cc.); indirect inguinal herniae, bilateral; fibrous peritoneal adhesions; cardiac hypertrophy and dilatation (580 grams); arteriosclerosis of aorta and medium sized arteries; acute passive hyperemia and edema of lungs, marked; atrophy of spleen; arterial and arteriolar nephrosclerosis with retention cysts, bilateral.

COMMENT

The occurence of volvulus of the ileum with knot formation is unusual. In 239 cases of intestinal obstruction Barbarosa[1] reported 25 cases of volvulus of which 15 were of the large intestine and 10 were of the small intestine. Kaufmann[2] states that the incidence of volvulus is greatest in the sigmoid, followed in frequency by the small bowel and rarest in the cecum. Milroy[3] reports that intertwining of two or more loops of bowel is considerably more rare than volvulus due to twisting of the bowel about its mesenteric axis. Intertwining of a loop of ileum with a loop of sigmoid is more common than intertwining between two loops of ileum[2,3].

Volvulus is rare in the presence of a normal intestine, mesentery and abdominal cavity. A predisposing factor of great significance is the partial fixation of one portion of the gut and a normal or increased motility of an adjacent segment which facilitates twisting on the mesenteric axis. Partial fixation may be congenital due to malrotation of the gut or because of a

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Selected by H. T. Karsner, M.D., from the Clinical Pathological Conferences at the Institute of Pathology, Western Reserve University and University Hospitals, as the thirty-third of a series of cases to be published under the heading "Case Records Presenting Clinical Problems".

Meckel's diverticulum or fixation may be acquired as the result of fibrous adhesions. Fixation of the gut may occur in a hernial sac. Increased intestinal mobility may be the result of a congenitally long mesentery, or acquired by the loss of mesenteric fat, or by the relaxation of the abdominal musculature. Occasionally abdominal tumor may be a factor in initiating the torsion of the gut. Violent peristaltic activity, the result of dietary indiscretions or of strong cathartics, may be a precipitating factor in the production of volvulus. In 37 cases, McKechnie and Priestly[4] reported eight cases with congenital anomalies, 26 cases with acquired fixation, and three cases in which no cause could be found. There were four cases of Meckel's diverticulum and two with malrotation of the gut. In 21 cases adhesions were present, of which 14 were postoperative, two were the result of known inflammation, and in five no cause was found. Three of their cases appeared in the immediate postoperative period.

In the series of McKechnie and Priestly[4] the age incidence ranged from the newborn to 78 years of age, with the greatest incidence in the third decade. Bockus[5] states that volvulus is a disease of late adult life. The occurrence of volvulus in older age groups is easily understandable when it is remembered that the acquired predisposing factors, namely, intestinal adhesions, herniae, loss of mesenteric fat, and relaxation of the abdominal musculature, usually occur in older age groups. Those cases that are predisposed by such congenital anomalies as malrotation of the gut usually occur in infancy or early childhood.

There are no pathognomonic signs or symptoms of volvulus of the small intestine. The clinical picture does not differ from that of small intestinal obstruction from any cause. Severe abdominal pain, either continuous or intermittent, occurs early and is usually followed by nausea and vomiting which frequently dominates the picture. Tenderness appears early. Distention occurs late in the course of the illness and may well be absent. The laboratory examination reveals the signs of dehydration and disturbed electrolyte balance subsequent to prolonged vomiting or may be non-contributory. The usual preoperative diagnosis is intestinal obstruction of unknown etiology.

Treatment is immediate surgical operation and should be given the patient as soon as an intestinal obstruction is suspected. Any delay may result in irreversible damage to the intestine because of impaired circulation in the involved segment of gut. The operative procedure of choice is detorsion of the gut and freeing of readily accessible adhesions. The volvulus tends to recur probably because the predisposing factors are still operating and possibly because of

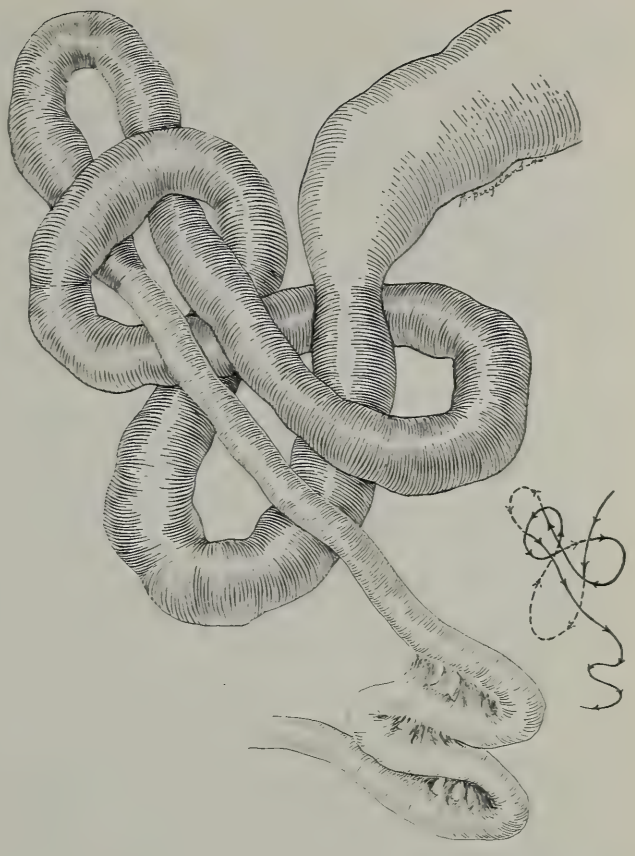


Fig. 1. Drawing of intertwined segment of ileum, with dilated proximal part of intestine and fibrous adhesions distal to the knot. The small diagram indicates the direction of normal peristalsis in the various parts of the knot.

stretching, and changes the result of the first episode of volvulus.

In reviewing the clinical course of this patient, several interesting points are noteworthy. Although this patient was ill on admission, there were remarkably few signs or symptoms even to suggest that his disease was dangerous. The past history of arteriosclerotic and hypertensive cardiovascular disease with mild cardiac failure over a five-year period, plus only mild abdominal distress, two episodes of vomiting, and an electrocardiogram interpreted as showing a digitalis effect, no doubt suggested that all the complaints were on a cardiac basis. In retrospect it might be suggested that a fall in blood pressure from previously established levels of 180 to 200 systolic and 100 to 120 diastolic to the admission level of 120 systolic and 90 diastolic, in the absence of severe cardiac decompensation, might have been a clue to the seriousness of the disease. The lungs presented the anatomical picture consistent with that found in shock.

The appearance of the adherent distal segment of gut suggested that at one time it had been incarcerated in the inguinal hernial sac. It is interesting to speculate as to whether or not the fixation of the gut in the hernia had been a predisposing factor in the development of the volvulus with subsequent reduction of the hernia,

perhaps as a result of tension from the dilated small intestine.

SUMMARY

A rare case of volvulus of the ileum with intertwining loops and knot formation in a man 70 years old is presented. Of interest was the lack of clinical evidence to suggest the severity of the disease before the patient was found dead in bed after having been in the hospital only six hours.

BIBLIOGRAPHY

1. Barbarosa, J. J. deC.: Volvulus of the Entire Small Intestine and Its Mesentery. Am. J. Surg., 64:400, 1944.

2. Reimann, S. P.: Kaufmann's Pathology. P. Blakiston's Son & Co., Philadelphia, vol 1, p. 746, 1929.

3. Melroy, P.: Volvulus of the Intestine with Intertwining Loops. Lancet, 2:809, 1940.

4. McKechnie, R. E., and Priestly, J. T.: Volvulus of Small Intestine; a Report of 37 Cases. Am. J. Surg., 34:286, 1936.

5. Bockus, H. L.: Gastroenterology. W. B. Saunders Co., Philadelphia, Vol. 2, p. 317, 1944.

Tuberculosis

Tuberculosis control among nurses starts with the entrance of the student nurse in the school of nursing. Most schools require a pre-entrance physical examination of the student by her family physician, but few make the tuberculin test or chest radiogram a prerequisite. The technic of tuberculosis control is simple and easy indeed when compared with the complicated and expensive mechanism of silicosis prevention. Yet tuberculosis control among nurses is lagging far behind the control of silicosis in industry. This is indeed an anomalous situation.—M. Pollak, M.D., Am. Jour. of Nursing, Dec., 1944.

* * *

The diagnostic value of the tuberculin test is inversely proportional to the frequency of tuberculosis infection in the community from which the patient comes. In recent decades the incidence of positive tuberculin tests in many sections has declined to such a marked degree that the tuberculin test is assuming a position of steadily increasing importance among the diagnostic procedures that may be used to aid in the identification of obscure lesions, either within the thorax or elsewhere, which may bear some clinical resemblance to tuberculosis. For many years pediatricians have employed the tuberculin test much more frequently than have physicians who treat adult patients. This has been due in part to the fact that positive tuberculin tests are much less common among children than among adults. Now that the incidence of positive tuberculin reactions has declined among adults, the tuberculin test will surely be used with steadily increasing frequency in time to come.—H. Corwin Hinshaw, M.D., Mayo Clinic, Rochester, Minn.

Fluorine, a Deterrent in Dental Caries

Fluorine in drinking water has been known to dental investigators for years. In fact in 1908 in Colorado Springs, Colorado, McKay observed a so-called "brown stain" on the teeth of many individuals native to the community and also noted that the caries rate was markedly less than in other communities where the "brown stain" was not prevalent. These observations led to further investigations and disclosed that high concentrations of sodium fluoride was present in the drinking water and was the cause of the "brown stain" or mottled enamel.

Dean and his associates have since furnished conclusive evidence that the rate of caries attack is markedly less in towns in which fluorine is a natural constituent of drinking water than in other towns of comparable populations where the water is free of fluorine. This same investigator reported "that continuous use of domestic waters containing as low as one p.p.m. of sodium fluoride was associated with a relatively low dental caries experience and only sporadic instances of mild dental fluorosis (brown stain or mottled enamel) were found." Other investigators have substantiated these findings and recorded numerous other studies along the same line. These data, however, are all collected from waters that naturally contain fluorine. Can sodium fluoride be added artificially to drinking water in nontoxic doses and yet produce favorable effects upon dental caries?

Two demonstrations are now in progress in the U. S. to test this theory. In July, 1944, a special session of the Common Council of Grand Rapids, Michigan, was called to consider the application of sodium fluoride in the concentration of one p.p.m. to the public water supply. Upon approval the test was started on January 25, 1945, and is to last at least 10 years. This water supply furnishes drinking water to approximately 170,000 population. Over 31,000 school children were given dental examinations to establish base line data for evaluating results. As a part of this examination saliva samples were taken from 600 children and counts made of the lactobacilli present in the mouth of each child. Several thousand children will be examined annually to determine variations that have taken place from this base line. Muskegon, Michigan, with a population of approximately 48,000 is to be used as a control community.

At Newburgh, New York, a similar demonstration has been set up using the town of Kingston as a control.—Franklin M. Erlenbach, D. M. D., Hartford; Conn. State Medical Journal, Vol. X, No. 9, September, 1946.

Expansion of Consumer Co-ops, Including Medical Care Programs, With Aid of Labor Unions, Planned; Federal Health Insurance Given Boost at Columbus Meeting

SPECIFIC plans "for a greater American cooperative movement" which has as one of its objectives "the cooperative acquisition of agencies of distribution and production", including those engaged in the distribution of health and medical services, were consummated at the National Cooperative Congress held in Columbus on September 7-11.

The congress, which was attended by representatives of the Cooperative League of the United States of America, Cooperative Finance Association of America, the National Cooperatives, Inc., and of various consumer cooperative medical care organizations throughout the country, pledged itself to:

1. Support "national health insurance under public auspices" providing any government plan would provide for Federal loans to consumer sponsored agencies for hospitals, clinics, and equipment and would not restrict the development of consumer sponsored and controlled medical care plans;

2. Aid in the organization of additional consumer cooperative medical care plans;

3. Work with labor unions and other groups in the organization and development of consumer cooperatives in cities and metropolitan areas.

LINCOLN SOUNDS KEYNOTE

Keynote of the meeting, at which action was taken on dozens of economic, social, and governmental subjects in addition to medical and health questions, was sounded in the address of the president of the Cooperative League of the U.S.A., Murray D. Lincoln, Columbus, also president of the Ohio Farm Bureau Federation.

Referring to the conference, Lincoln said: "Let us hope that out of it will come specific plans for a greater American cooperative movement. The job is urgent and the time is short. Let's make the most of it."

Observing that "American business enterprise watches our development with interest and concern", Lincoln pointed out that "dollar values in both rural and urban cooperatives have climbed steadily"; that farm cooperatives continue their steady expansion into more and more fields of operation; that "the American public today is at the mercy of a profit minded business system which is determined to exact the greatest possible toll from the consumer"; and that he sees no force but consumer cooperatives which can offer an acceptable alternative "to either chronic insecurity on one hand or statism on the other".

LABOR'S SUPPORT GIVEN

Lincoln's plea that "every encouragement" and "every possible aid" be given to "co-op minded labor groups" was supported in an address prepared by Walter P. Reuther, president of the United Auto Workers of America, C.I.O., and read to the congress by one of his representatives in Reuther's absence.

Reuther revealed that his union is meeting with national and regional co-op leaders in setting up coordinating committees which will supervise the co-op organizing drive in urban areas. He predicted that this activity will lead to increased political unity among industrial and agricultural workers, stating that "as we learn to pull together on the economic field, we will learn to act together at the ballot box". Voicing his views as to how America should be mobilized for a program of "freedom and abundance", Reuther offered the following as one of his courses of action:

"Finally, we must push a broad educational and organizational program to pool the economic power of workers and farmers in powerful cooperative enterprises that will challenge, and compete with, privately owned enterprises."

URBAN COOPERATIVES URGED

A resolution adopted by the delegates urged that every regional member of the Cooperative League "assist with every available means" the development of cooperatives in urban areas by aiding the establishment of cooperative committees in labor unions and by providing consultation and literature.

The Secretary of Labor was requested, in a resolution which was introduced, to recommend to the Congress of the United States the establishment of a division of consumer cooperation in the Bureau of Labor Statistics, a division which would collect statistics, issue educational material, and "perform such other services as may be desirable". This proposal was referred to the board of directors of the league for further consideration because of the "danger that it might identify the Agricultural Department as the champion of agricultural cooperatives and the Labor Department of labor cooperatives", thus creating possibility of friction.

More than 40 resolutions were handed to the

delegates two hours before the time set for adjournment of the congress. These proposals had been drawn by a committee of 11 persons previous to the meeting. One member of the resolutions committee was Harry Culbreth, educational director of the Ohio Farm Bureau Federation. All resolutions were acted upon during a three-hour period.

WANT MEDICAL COOPERATIVES

Following through on recommendations which had been made in talks by top-flight officials of some of the consumer cooperative medical plans in various parts of the country, the delegates adopted, without discussion, the following resolution, headed "Health":

"Millions of people still suffer needlessly from inadequate distribution of medical care in spite of the outstanding progress of medical science.

"This congress commends the medical professions for their signal contributions to the scientific developments which now make possible the wider and more effective distribution of medical care.

"The congress commends the medical cooperatives and group health associations for their pioneering efforts in enabling consumers to obtain fuller use of medical services through various types of prepayment plans. It further commends them for their recent action in organizing the Cooperative Health Federation of America.

"The Cooperative League has consistently supported and encouraged the development of such voluntary health plans. It gave encouragement and assistance to the meeting which resulted in the incorporation of the Cooperative Health Federation of America. It now urges all cooperatives affiliated with the League to sponsor the establishment of organizations through which the people in their respective areas can obtain medical, hospital, and other health services on a cooperative prepayment basis. It further urges that such organizations will affiliate with the Cooperative Health Federation of America and assist in the distribution of health and medical care on a cooperative basis.

"This Congress recognizes that the efforts of the cooperative movement alone can not insure in the near future the distribution of adequate health care to all of the people of the United States. For this reason it approves the principle of public responsibility for assuring the availability of health and medical services for the people without economic or other barriers. To this end it supports:

"1. The making of larger grants by the Federal Government to the states for public health purposes.

"2. Nation-wide health insurance under public auspices provided that any proposed government action in this field:

"(a) Provides for the continued expansion of volunteer cooperative health and medical care plans on a basis that will permit consumer control of administrative and organizational policies.

"(b) Provide for local control through maximum decentralization of administration.

"(c) The making of Federal loans to consumer sponsored agencies for hospitals, clinics, and equipment.

"(d) Provide as a condition for state participation in a national health program that there shall be no state policies which restrict the free development of consumer sponsored medical care plans."

NATIONAL FEDERATION ORGANIZED

The Cooperative Health Federation of America, mentioned in the resolution, was organized on August 18 at Two Harbors, Minnesota, for the purpose of coordinating the efforts of various cooperatives to expand consumer sponsored medical care plans and cooperative-owned hospitals. Culbreth, who served as a member of the resolutions committee, is one of the members of the board of directors of the cooperative health federation. The Two Harbors meeting was attended by representatives of the American Medical Association whose report was the basis for an editorial published in the August 31 issue of *The Journal of the A.M.A.*

During the Columbus meeting a number of the directors of the cooperative health federation who were in attendance, issued to the press a lengthy bulletin regarding the formation of the federation, its purpose, and its plans. According to this announcement, the Cooperative Congress while in session in Columbus took five major steps to speed the work of the new cooperative health federation, as follows:

FIVE-POINT PROGRAM

1. A drive for affiliation of all prepaid medical care plans in which consumers have effective control.
2. The creation of a labor committee with headquarters in Washington.
3. The appointment of the Washington representative of the Cooperative League as agent for the Federation which will be incorporated in the District of Columbia.
3. The election of a small executive committee with doctor representation to speed the work of the new organization.
5. The selection of Minneapolis as temporary headquarters.

It was indicated by one of the officials of the organization that a budget of $30,000 will be sought by the federation in order to maintain a central office and an extensive field organizing staff. One of the services to be offered will be a consultation bureau to provide legal and administrative aid, and to "set high quality professional standards for medical care plans".

OFFICIALS OF NEW GROUP

The newspaper hand-out also stated that Dr. Michael Shadid, Elk City, Oklahoma, medical cooperative director, had been named president

of the new federation and that other officers included: George Jacobson, Group Health Mutual of Minneapolis, secretary-treasurer; Harry Becker, president of Group Health Association, Washington, D.C., and Dr. Elmer Richman, medical director of Labor Health Institute, St. Louis, vice presidents. Becker, who is an employee of the Children's Bureau, was chosen chairman of the "Labor Project for Medical Care" which will have headquarters in Washington, D.C.

In the announcement, Jacobson revealed that the following had been accepted on the Board of Incorporators: James Carey, national C.I.O. secretary; Nelson Cruickshank, A. F. of L. social security director; Gladys Talbot Edwards, Farmers' Union; Dr. Dean Clark, Health Insurance Plan of New York; Dr. John T. Lawrence, Washington University, St. Louis; and Harry Culbreth, Ohio Farm Bureau, Columbus.

The officers and organizers plan a meeting in St. Louis on October 5 and 6 for the purpose of completing organizational activities and drafting plans for a promotion campaign, it was announced.

Scheduled to speak at the Columbus meeting before the section on co-op health plans, Becker was unable to attend but sent to represent him the director of public relations for Group Health Association of Washington, D.C.

A.M.A. IS CRITICIZED

Describing the American Medical Association, the American Hospital Association, and the National Physicians Committee as "a monopoly which is real and uses present laws to accomplish its aim", this speaker stated that without national legislation in the medical care field "we will never get out of the chicken coop stage".

Stating that cooperative plans can't give all the answers, he declared that "we need the public health services government renders". Continuing, he said that "we need the activities of the Children's Bureau and others which supplement, reinforce, and make complete medical services", and a government administered national health insurance program. He declared that a cooperative can not be built which can provide for all of the people, therefore a government program with policy and medical standards controlled by the consumer agencies is necessary.

TO MAKE OWN DRUGS

Speaking briefly in the same section meeting, Dr. Shadid announced that "we have in mind for the future the manufacture of our own drugs and handling them cooperatively". This, he said, must begin with cooperative wholesaling. Shadid said that no prepayment plan can function successfully and yet be on a fee basis "because the doctors tend to chisel on the fund". He recommended that his booklet, "Cooperative Hospital Catechism", an appeal for physicians to enter cooperative medicine, be distributed to medical officers released from the armed services.

Chief objection to the prepayment medical care plans sponsored by the medical profession, as voiced by Cecil Crewes, Consumer Cooperative Association of Kansas City, is that they are producer cooperatives controlled by the doctors who dictate policy. He contended that the Blue Cross Plans are not democratic, but "as far as we know are controlled by the doctors". Crewes is a third vice-president of the cooperative health federation.

Ohio G. O. P. Plank Opposes Socialization of Medicine

Following is an excerpt from the statement of principles concerning domestic affairs, included in the platform adopted at the Republican State Convention held in Columbus, September 10:

"States and their subdivisions must furnish subsistence, shelter, and medical care to their citizens who are unable to provide for themselves. Federal aid, including public assistance, must be based on State and local initiative, operation, and responsibility, without Federal bureaucratic interference. We must avoid socialization of the medical profession and federalization of unemployment compensation. Federal aid must be in amounts which do not impose an unreasonable burden of taxation on the rest of the population who pays the bills."

PG Course in Allergy Offered Scholarships Available

A postgraduate course in allergy will be offered by the American College of Allergists during the week of November 4 at the Jefferson Medical College, Philadelphia.

The course will present a faculty of instructors representing 17 medical schools and four clinics, as well as research workers, botanists, and outstanding physicians in allied fields of clinical medicine. There will be 46 lectures, in addition to clinics and an afternoon laboratory session.

A limited number of scholarships are available to residents and internes interested in allergy or now on an allergy service in some hospital. Details and application blanks are obtainable from the office of the American College of Allergists, 401 La Salle Medical Building, Minneapolis 2, Minnesota.

Several Bills of Interest to Medical Profession Are Enacted at Recent Special Session of Legislature

SEVERAL Bills of special interest to the medical profession were enacted during the Fourth Special Session of the State Legislature held at Columbus, August 20-23. Included were measures liberalizing benefits for the aged and blind; appropriation of $15,665 during the current year for a survey of hospital facilities in Ohio; and an amendment to the Medical Practice Act temporarily waiving certain legal requirements so as to enable several former medical officers to qualify for licenses to practice medicine and surgery in Ohio.

FUNDS FOR MEDICAL CARE VOTED

S. B. 267 increases the maximum award payable to an old age pensioner from $40 to $50 per month. Also it makes possible an additional allowance up to $200 per calendar year to reimburse a recipient of aid-to-the-aged, for expenditures made for medical, dental, optometrical, or hospital care. The latter provision is contained in an amendment to the bill reading as follows:

"Provided that in cases of extraordinary need and in so far as not in conflict with the basis of need established in or under federal law, an additional allowance of not to exceed $200 in any calendar year may be made, in accordance with schedules adopted by the division, for medical, dental, optometrical, or hospital care."

Representatives of the Ohio State Medical Association have been requested by officials of the State Division of Aid to the Aged to assist them in formulating policies and regulations governing the extra allowance for medical care.

S. B. 375 provides that county commissioners may pay up to $50 per month, instead of $40, to persons entitled to aid for the needy blind. Such persons may also receive up to $200 during a calendar year in cases of "extraordinary need" for "medical, dental, or hospital care".

HOSPITAL SURVEY APPROVED

S. B. 374 appropriates $15,665 to the State Department of Health for the balance of 1946, for the purpose of initiating a state-wide hospital survey.

S. B. 368 facilitates the licensure of a few Ohio physicians who served as medical officers with the armed forces during World War II, but who were unable to qualify in Ohio because of certain technical provisions of the General Code. Enactment of such a bill for their benefit was requested by Governor Frank J. Lausche, who pointed out that the legislature had previously passed special legislation in behalf of engineers, surveyors, pharmacists, and teachers who had been in the service. The act is in effect until August 28, 1950.

PROVISIONS ENUMERATED

To take advantage of S. B. 368, an applicant must have served as a commissioned medical officer in the Army, Navy, or the United States Public Health Service between October 14, 1940, and September 2, 1945, and must have been separated from the service under conditions other than dishonorable. He must make application to the State Medical Board within two years of his separation from such service.

If he is a graduate of an approved medical school and holds a license to practice medicine and surgery in another state, the Board may issue him a license to practice in Ohio without a written examination.

A graduate of an approved medical school, who meets the other requirements of the law, but has not been authorized to practice in another state, may be permitted by the Board to take the regular examinations for a license to practice in Ohio.

MUST SHOW EXTRA TRAINING

If the discharged medical officer is a graduate of an unapproved medical school and was a legal resident of Ohio continuously for at least one year next preceding the effective date of the Act—August 28, 1946, he may be permitted by the Board to take the examinations for a license to practice in Ohio, provided he submits satisfactory evidence to the Board that he has taken postgraduate instruction or intern service amounting in the aggregate to 36 weeks in an institution or hospital approved by the Board.

As of September 15, six former medical officers had applied to the State Medical Board for permission to qualify for licensure under the provisions of S. B. 368.

V. A. Needs More Nurses

At least 200 qualified nurses are needed immediately for assignment in certain Veterans Administration hospitals in Ohio, Michigan, and Kentucky, it was announced today by Miss Frances Hellman, Supervisor of Nurses, at the Veterans Administration Columbus Branch Office. Salaries, commensurate with training and experience, range from $2,644 to $3,397 annually for staff nurses in the junior grade. Instructors and head nurses in the associate grade receive from $3,397 to $4,149.

November 5 Is The Day . . . .

when the voters of Ohio will elect various public officials, including their representatives in the United States Congress and the Ohio General Assembly.

Physicians Have A Big Stake . . . .

in the outcome of this all-important election. Actions of legislative bodies during the next two years may set the pattern for medical and health activities of government for years to come.

Are You Prepared . . . .

to vote intelligently? Your vote for candidates who on their records or by reason of their beliefs are qualified for public office and who subscribe to sound practices and theories on medical and health matters is imperative.

Check On The Candidates . . . .

with the Legislative Chairman or officers of your County Medical Society. They have such information. Better still, talk with the candidates yourself. Find out how they stand on questions in which you are vitally interested.

Prior To Election Day . . . .

electioneer for those candidates who are qualified. Your vote will not be enough. Get your friends, acquaintances and patients to support and vote for those who think and will act constructively on medical and health proposals.

Medicine Has A Program . . . .

which all candidates should know about. Tell them about the 25-Point Health Program for Ohio; about Ohio Medical Indemnity, Inc.; about the Blue Cross programs; about present programs in which the medical profession and government are cooperating in providing medical and health benefits for the handicapped and needy.

Interest In Political Affairs . . . .

must be shown by each physician. While advancing its own constructive programs, the medical profession must defend those standards which have produced progress. Those who are demanding revolutionary changes will be active. The chips are down. The medical profession can not afford to pull its punches. Sound-thinking men and women must be elected to positions of trust and responsibility. November 5 is the day—the day for the show-down.

Erection of Five State Tuberculosis Hospitals and Aid for Local Institutions Recommended by Committee

A REPORT on the weaknesses of Ohio's tuberculosis control program and recommendations on ways to correct this situation were submitted to Governor Lausche on September 19 by a Joint Committee on Tuberculosis Control which had been requested by the Governor to study the needs of Ohio in this health field.

Major findings and recommendations of the committee include the following:

HOSPITAL FACILITIES

The number of beds for the care of the tuberculous in the State are inadequate. The state provides no facilities for the hospitalization of the sane tuberculous, all tuberculosis hospitals being owned and operated by district, county, or private agencies.

The ownership, number, and bed capacity of tuberculosis hospitals in the State are as follows:

Ownership	Number of Hospitals	Bed Capacity
County	16	2866
District	3	288
Private	3	273
Total	22	3427

In 1945, 2,573 deaths in Ohio were attributed to tuberculosis and the available beds numbered 3,427, a ratio of 1.3 beds per tuberculosis death. The National Tuberculosis Association recommends a ratio of 2.5 to 3 beds per tuberculosis death. Thus, the State of Ohio, apparently needs at least 3,000 additional beds.

Because energetic case-finding programs are revealing 70 per cent of the cases in the earliest stage when they are most amenable to treatment, it is felt that somewhat less than the recommended increase in beds is necessary.

A building program should provide for a minimum of 1,100 additional bed facilities for all citizens of the State under appropriations to be made by the General Assembly for 1947. The need should be met as follows:

One new hospital (at Columbus, a teaching hospital affiliated with Ohio State University)	**300 Beds**
Four new hospitals (of 200 beds each, at other designated locations in the State)	**800 Beds**
Total	**1100 Beds**

The total cost of land, buildings, and equipment for this building program is estamiated at approximately $9,300,000.

STATE AID TO COUNTIES

Hospitalization of the patient suffering from tuberculosis is basically a public service in the interests and for the protection of community health.

Economic and administrative barriers which deprive the individual of needed hospital care should be eliminated as far as possible. The average daily cost of hospital care for a tuberculous patient in Ohio has increased from a low of $2.92 in 1941 to $4.60 in 1945. Less than 4 per cent of persons with tuberculosis are able to pay for their hospital care without reducing economy of the family to a bare subsistence level.

The cost of care and treatment of the tuberculous for the counties was $4,436,411.49 in 1944. Those counties with insufficient resources have been unable to build needed facilities for treatment or allocate funds for care of their tuberculous people, while the larger counties have been forced to build hospitals and assume staggering maintenance costs to keep them in operation.

The Committee recommends that the State adopt a policy of State aid to counties for care and treatment of persons suffering from tuberculosis. Each county should receive the sum of $2.50 per diem for each patient hospitalized in any State, county, district, or other tuberculosis hospital in the State approved by the Ohio Department of Health.

The total annual cost of this program of aid to the counties for hospital care of tuberculous patients is estimated at $3,250,000.

DIVISION OF TUBERCULOSIS

On December 10, 1945, the Division of Tuberculosis was reactivated in the Ohio Department of Health. It has been entirely sustained through Federal grants-in-aid funds allocated for the purpose to Ohio by the U. S. Public Health Service.

The Committee feels that there is no justification for the State continuing to depend upon Federal government appropriations to finance this Division. Critical analysis and appraisal of the program indicates the necessity for the State to accept its responsibility for maintenance of the Division of Tuberculosis. Only in this way can the efficiency and productivity of the services of the Division be strengthened and de-

veloped. **The recommended annual appropriation for the Division of Tuberculosis is $50,000.**

SUPPORTING DATA

Among interesting data submitted by the Committee included the following:

In 1944, 2,754 persons in Ohio died of tuberculosis. Of this total, 89 per cent occurred in the age group of 19 years and over. In this same period, tuberculosis was a leading cause of death in the age group 12 to 35 years. There were approximately twice as many deaths from tuberculosis in this age group as there were from heart disease which ranked second.

In a comparison of tuberculosis deaths with other communicable diseases, it was found that for every death for measles, there were 18 deaths from tuberculosis; for every death from scarlet fever, there were 61 deaths from tuberculosis; for every death from diphtheria, there were 80 deaths from tuberculosis; and for every death from typhoid fever, there were 160 deaths from tuberculosis.

Careful group X-ray surveys have revealed from 8 to 14 cases of clinically significant tuberculosis for every single death caused by the disease.

The only tuberculosis sanatorium now operated by the State of Ohio, Mt. Vernon, is limited to the mentally ill, mentally deficient, and epileptic patients suffering from tuberculosis.

Only 29 counties of the 88 have access to tuberculosis facilities.

The average daily cost of hospital care for a tuberculous patient in 1941 was $2.92. In 1945, that figure had grown to $4.60.

In Ohio in the age group 25 to 44 years, deaths from tuberculosis in 1945 were three times greater in the unskilled workers than in the skilled; and eight times greater in the skilled than in the professional group. Fifty-one and four-tenths per cent of the men and 60.4 per cent of the women who died of tuberculosis at ages 25 to 44 were married.

Ohio ranks twenty-third in the list of states with a death rate of 37.4 per 100,000 population.

State sanatoria are maintained in 41 states. Twenty-one of 37 states which have local, publicly supported sanatoria provide subsidies from state funds which assist the counties to bear the financial burden of the care of the tuberculous.

About 96 per cent of tuberculous patients requiring hospitalization are dependent on public funds for all or part of the cost of their care.

PERSONNEL OF COMMITTEE

The committee included Carl A. Wilzbach, M.D., chairman, and 20 others representing seven state-wide organizations interested in public health, as follows:

Ohio Federation of Public Health Officials: Carl A. Wilzbach, M.D., Cincinnati; Walter H. Hartung, M.D., Toledo; H. G. Southard, M.D., Hocking and Vinton Counties.

Ohio Hospital Association: H. L. Rockwood, M.D., Supt., Warrensville Chronic Disease Hospital, Warrensville; Louis Blair, Supt., University Hospital, Columbus; L. C. Rittmeyer, Administrator, Dunham Hospital, Cincinnati.

Ohio State Medical Association: J. L. Webb, M.D., Nelsonville; C. E. Hufford, M.D., Toledo; Charles S. Nelson, Ex. Secy., Ohio State Medical Assn., Columbus.

Ohio Conference of Tuberculosis Secretaries: Whitney H. Herr, Ex. Secy., Mahoning County Tuberculosis Assn., Youngstown; J. Dean Halliday, Public Relations Dir., Anti-Tuberculosis League of Cleveland, Cleveland; Nona C. Simmerman, Ex. Secy., Montgomery County Tuberculosis and Health Association, Dayton.

Ohio Tuberculosis Hospital Association: H. H. Brueckner, M.D., Supt., Molly Stark Sanatorium, Box 367, Canton 1; E. F. Conlogue, M.D., Supt., Stillwater Sanatorium, Dayton; Wm. L. Potts, M.D., Supt., Franklin County Tuberculosis Hospital, Columbus.

Ohio Tuberculosis and Health Assn.: Wm. M. Morgan, Ph. D., Alliance; Azel Ames, M. D., Hamilton; George L. Lafferty, Lisbon.

Ohio State Nurses Association: Mrs. Esther Brubaker, R.N., Springfield; Vera Glover, R.N., Cuyahoga County Bd. of Health, Cleveland; Mildred Lambert, R.N., Dunham Hospital, Cincinnati.

Advisory Members (Ohio Department of Health): Roger E. Heering, M.D., Director; Mark W. Garry, M.D., Chief, Div. of Tuberculosis; J. E. Bauman, Chief, Div. of Administration.

To Continue Hospital Survey Work

The American Hospital Association has announced the establishment of a department for the purpose of continuing certain of the functions initiated by the Commission on Hospital Care which is disbanding on October 1. In cooperation with the United States Public Health Service, the Association will continue to code and tabulate hospital schedules for State survey commissions through the Chicago office of the American Hospital Association. The W. K. Kellogg Foundation and the National Foundation for Infantile Paralysis each have approved grants of $10,000 per year for two years for this activity.

The staff of the new department also will assist states with advice and with exchange of information in developing satisfactory study methods.

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

"STATE'S RIGHTS MEAN RESPONSIBILITIES"

(Editorial, September 21, 1946, issue. The Saturday Evening Post)

"LATELY there has been a renewal of the cry for State rights, and it is likely that this cry will grow louder as awareness of what has happened to our Government becomes widespread.

"It is not enough, however, to declaim against this trend, which, if unchecked, will result in a form of government entirely different from that which was originally planned by the founders of this country. Every result has a cause, and the principal cause of the vast centralization of power in Washington has been an insufficient assumption of responsibility by each of the forty-eight states, insufficient imagination in anticipating social reforms and little or no initiative in putting into effect the reforms that people demanded.

"The trend to Washington began with the depression, back in the 30's, when the states tried to meet a tremendous situation with horse-and-buggy methods. Laboring under Elizabethan poor laws, state agents shuttled American citizens from town to town, from state to state, under parochial settlement laws which had been on our statute books for two centuries. Residents of a state for eight or nine years found themselves peremptorily returned to their native state because they hadn't lived there continuously for ten years.

"Into this miasma of stupidity and shortsightedness stepped the Federal Government with its emergency-relief measures, and was welcomed by the people as a delightful contrast to the muddleheadedness of state and municipal officials who had largely bumbled the problem of work relief. From this initial step flowed the Social Security Law, which vested in the Federal Government complete control of old-age pensions, gave it the upper hand in the supervision of unemployment compensation, and further strengthened its hold by direct subsidies for child welfare, aid to the blind and other similar measures. It is needless to recount the continual growth of Federal subsidies, grants and assumption of power, and the docile acceptance of this easy money by states.

"These things are important to remember, because we are now emerging into another period—the period of postwar readjustment—which demands initiative, imagination and foresightedness. Are those who are speaking loudest against 'bureaucracy' and advocating a restoration to the states of their original power doing anything about these problems? One has to think only of the manner in which so many states waited anxiously to see whether or not Congress was going to pump life back into the battered OPA before passing a state rent-control law to realize that these lessons have not been fully learned. If other states had followed the lead of Gov. Thomas E. Dewey, of New York, and put a local ceiling on rents, one of the most compelling reasons for reviving OPA would have been removed.

TIME FOR OHIO TO WAKE UP

The accompanying editorial from The Saturday Evening Post didn't mention the great State of Ohio. Nevertheless, it's pointed barbs hit Ohio—and hard.

Let's look at the record.

For years Ohioans have been yelling about bureaucrats and Federal Expenditures.

Public office holders in Ohio, many of them, executive and legislative, have protested Federal domination, Federal control, Federal dictation, etc.

The average Ohioan will proudly admit that Ohio is a sovereign state, big enough to stand on its own feet, can run its own affairs, etc.

Yet, at the same time Ohio has been taking Federal handouts hand over fist. Every time the State Legislature meets, bills are put through to put Ohio on the Federal gravy train. Every time the Santa Clauses in Washington hash up a new "Federal aid" scheme, officials in Ohio almost strain a tendon getting enabling legislation passed, to let Ohio in on the cut-in.

Every time this happens, Ohio gives up another chunk of its independence and sovereign rights.

Are we going to be mice or men?

When are we going to wake up?

Let's get squared away on a consistent policy. Do we want the Federal bureaus running Ohio? It we don't, let's have enough guts to say so; let's tell them to keep their cash; let's analyze the job to be done in Ohio and then do it with Ohio money and Ohio personnel.

It's about time for Ohio to wake up.

"In condemning the swarms of Federal office-holders, the horde of Federal investigators, the inefficiencies and stupidities of 'bureaucracy', are the states at the same time setting their own houses in order streamlining their organizations and putting their best brains to work to do these things?

"Many who are aware of the fact that the Federal Government is one of granted powers, and that the fountain and residue of all powers rest in the individual forty-eight states are at the same time concerned about the states' willingness and ability to assume these responsibilities. Many thoughtful people would like to see a return of responsibility to the states, but wonder if they can meet it.

"That this can be done is evidenced by the manner in which some states, notably Connecticut, made preparations for the return of men from the armed forces by the creation of local veterans' centers. Because these local centers were going concerns on V-J Day, Selective Service authorities, who had originally planned to assume total responsibility for giving information and guidance to returning veterans, finally advised their local boards to work through local communities wherever possible.

"There has been a little encouragement along these lines, but not enough to date to warrant wholehearted optimism. Many state governments are still hopelessly inefficient, haplessly administered and helplessly floundering along without any concern except the immediate job of the day. They are still concerned with little problems.

"The states lost their power in the 30's because they had given evidence of their inability to exercise it. Power will not flow into a vacuum. It can be attracted only when the states, by their own energy and foresightedness, show that they are ready to shoulder their share of today's problems."

A VERY GOOD PRECEDENT, IN OUR OPINION

President Truman when he signed S. 191, the Hill-Burton Hospital Construction Act, was quoted as saying that he did so with some reluctance because, in his opinion, it established several precedents which were not to his liking.

One of these, it is reported, is that provision of the bill which specifies that Federal responsibility ceases after a hospital is built and ready for operation. From that point on, the state or community, which had to contribute two-thirds of the costs of construction, shall assume full responsibility for the maintenance and operation of the institution.

If those who want to see the Federal Government run the main show and all the sideshows don't like this stipulation, it must be a good one.

Congress is to be congratulated for having inserted this safety clause. Some day Congress is going to wake up and find that similar safeguards should be inserted in all of the grants-in-aid programs of the Federal Government, assuming that any or all of them should be continued, which is a debatable issue.

WHAT IS YOUR I.Q. AS A PUBLIC RELATIONS MAN?

> "The best public relations man in industry is the salesman. The good salesman sells his product honestly. He also sells the organization he represents on a basis of its integrity and its product. The best public relations men in organized medicine are the private practitioners. If they practice honest medicine and express their honest, substantiated opinion during this critical period, they, as individuals, can guide public opinion in favor of organized medicine more effectively than any organized group."

The above is what the editor of *The Journal of the Medical Society of New Jersey* thinks about public relations.

If true, and we believe it is, the Ohio State Medical Association has approximately 7,000 public relations men on its staff. Some are good public relations men; some indifferent; some poor ones. Check your own day-by-day dealings with your patients—the customers—for your I.Q.

Medical public relations is not some mystical hocus-pokus. It is simply a combination of informing the people about what the medical profession believes in and stands for and of maintaining the right kind of physician-patient relationships. The first technique is the joint responsibility of medical organizations and the individual physician; the second, the sole responsibility of the individual physician.

"MUST" READING FOR ALL MEDICAL NEOPHYTES

We welcome to the Ohio fold of official medical society publications *The Clark County Medical Society Journal,* being published under the direction of a Publication Committee, headed by Dr. Howard H. Ingling. Other members of the committee are: Dr. Ray M. Turner, Dr. Will Ultes, and Dr. G. M. Lane. Success, good luck, and long life to this new venture!

Incidentally, in a recent issue our newest contemporary offered the following editorial commentary which should be "must" reading for medical neophytes:

"'But I have no tools,' said the young doctor to the old retiring physician.

"'Tools, My Lad,' said the old man in reply, 'You have the most important tools of medicine with you right now. You have your eyesight for keen observation. Use it. You have your hands for tactile perception. Examine every hole in your patient's body. You have your

ears to hear. Listen to what your patient has to say. You have your own voice to bring out more that the patient hasn't already told you. And you have your brain that the medical school has stimulated and started in definite channels of thinking. You have your pen to write prescriptions for any type of medicines known.

"'As time goes on you'll be able to lengthen your senses by mechanical means. Your own senses can never be replaced by mechanical means. In my early days we had the stethoscope and the knife and that was about all, son. I'll venture to say that we didn't venture too far from wrong. Don't do 100 dollars worth of work my boy for a $2.00 diagnosis. When you are able financially and in skill to obtain tools choose them wisely and slowly. Choose a few good tools, learn how to use them well and depart from the use of them for newer and stronger tools only when your old tools fail you and when you have learned how to use the new ones.'

"How well we can listen to our forefathers today. Let us sharpen up those native tools that we have and let the mechanical tools be aids rather than director in our diagnosis and treatments in medicine."

HAS OHIO TOO MANY LOCAL HEALTH DEPARTMENTS?

Speaking before the recent Conference of Ohio Health Commissioners with the Ohio Department of Health, Dr. Haven Emerson discussed the report, "Local Health Units for the Nation", prepared under his direction by a committee of the American Public Health Association. An abstract of this report was published in the July, 1946, issue of *The Journal.* After listening to Dr. Emerson, we can't pass up an opportunity to refer again to the subject.

Without referring specifically to Ohio or stepping on anyone's toes, Dr. Emerson pointed out that one of the biggest weaknesses in present-day public health administration arises from the fact that because there are so many local health departments too few of them are strong enough financially to do an efficient, up-to-date job.

Let's look at the situation in Ohio.

It has 203 local health departments. Every blessed person in Ohio wants the protection of an efficiently operated health department. Many Ohioans are not getting that kind of service. They may not know it, but they are not. Why? Simply because too many of these 203 departments can't possibly do the job on their respective budgets. Why not increase their appropriations, some may ask? The answer to that is easy: It can't be done in many of them simply because the basic economy of the area won't support a more liberal allowance. So what?

Dr. Emerson's suggestion as to how to meet this situation is through the combination of existing health districts or the formation of new districts to cover larger areas, thus enabling political subdivisions to pool their funds for the maintenance of a strong, well-financed, and adequately-manned department.

There are many who think this is the answer to Ohio's difficulties. Certainly it is a suggestion which warrants consideration. It may be a relatively painless way of solving the problem which everyone knows exists. It may be the way for Ohio to put its own house in order. It may be the way for Ohio to get off the hand-out list of Uncle Sam.

Commenting on the matter of subsidies, Dr. Emerson adroitly pointed out that a tax dollar sent to Washington—to Columbus, for that matter—is never the same dollar when it comes home. It has nicks in it.

TIME FOR SOME JOINT ACTION

The Cleveland Press has charged that an abortion ring and racket are operating in that area "with little fear of arrest or prosecution".

As pointed out by *The Press,* the practice "is contrary to law . . . contrary to the ethics of the medical profession".

In our opinion here is a joint job for the law enforcement agencies of Cuyahoga County, the City of Cleveland, and the Cleveland Academy of Medicine.

How about getting busy?

REPORT ON DEFLATION OF INFLATED WITNESSES

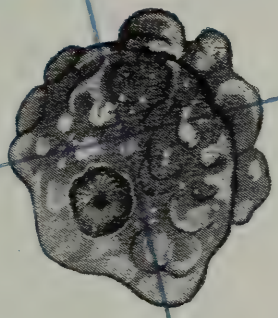
In the bulky record of testimony given before the U. S. Senate Committee on Education and Labor regarding the Wagner-Murray-Dingell Bill are some intensely illuminating bits of information about the background of some of the organizations "fronting" for compulsory sickness insurance and the inter-locking affiliations of some of the witnesses.

Mr. N. R. Howard, editor of the *Cleveland News,* in a recent "Editor's Column" extracted from the mass of verbiage a few illustrations which would be humorous if the subject under discussion had not pertained to social doctrines which are alien to what the history books call American democracy. Mr. Howard also pays a well-deserved tribute to Senator Forrest Donnell who cross-examined witnesses and drew from many of them significant admissions. Our hat is off to Mr. Howard and to Senator Donnell, both of whom have rendered a real public service in their respective fields.

Following is Mr. Howard's thumb-nail sketch, based on the printed testimony, which is enough to give anyone an idea of who's who behind the drive for federalization of health and medical services:

A sharp-faced little Republican from Missouri, Senator Forrest Donnell, stands out in the hundreds of pages just published on the testimony taken early in the summer on the "gov-

practically everywhere





. . . including the temperate zones, an unexpectedly high percentage of carriers of Endamoeba histolytica is to be found.

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—potent amebicide—can be used in suspected as well as proved cases of amebiasis.
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SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

ernment health insurance" bill hearings. The testimony was before a Senate body whose New Dealer members, including Senator James Murray, tried their best to rush an approval of this measure. On the second day, Murray and Senator Robert A. Taft had an angry quarrel and Taft walked out. . . . Fortunately, slenderish Senator Donnell remained to ask all the good questions.

* * *

He has a quiet, imperturbable manner born of many a courtroom joust, which manner, I judge, did as much deflating of inflated witnesses among those paraded before the committee as his searching questions.

He aimed at all high-sounding titles. A professor from New York, urging the bill, appeared for the "Union for Democratic Action". Let's see, said Donnell, wasn't that the organization which had a one-time Communist editor as its prime leader some years ago? . . . Yes, it was.

The president of the Group Health Association appeared, just as a citizen, he said. Oh, said Donnell, but I seem to remember you are on the Labor Department payroll. . . . Yes, he was.

The "Physicians' Forum" he inquired into through its president; what, it had only 2,000 members? How many members, asked Senator Donnell, does the American Medical Association have? Ah, many thousands? And, unlike the "Physicians' Forum", it was opposed to this bill? Oh.

Clark Foreman appeared to testify for the bill on behalf of the Southern Conference for Human Welfare. Senator Donnell was intensely interested in the makeup of this conference. How many were on its board? How did it pass resolutions? Dr. Foreman finally admitted the conference really had passed no resolutions about this bill. He was just endorsing it as a private individual. Oh, said Senator Donnell.

* * *

Harold Ickes and Secretary of Labor Schwellenbach appeared for the bill. Donnell elicited from both the admission they had not read the bill and did not know its provisions. When Fiorello La Guardia followed them, Donnell mixed him all up, finally had La Guardia endorsing the bill if they would change some of its provisions. He was another who hadn't read it.

When Arthur J. Altmeyer, Social Security bureaucrat, took the stand, Donnell, asking a hundred questions, got the information that Isidore Falk, statistician of Social Security, was the man who had actually written the bill—not its purported authors, Senators Murray and Wagner and Representative Dingell. So, reflected Donnell, the bill really didn't come from the people's representatives at all; was it Falk's original idea?

Just who was Falk, besides being on the government payroll? He identified Falk finally as a man with "lieutenants" in many other offices of the government, chiefly Labor, Interior, and Agriculture Departments.

* * *

It was Senator Donnell who classified the total of witnesses for the bill as "federal payrollers", 16; Democratic, P.A.C., or other left wing characters, 23; social workers, 15; labor leaders, 6; others who declined to endorse the health insurance feature, 8.

Of this last classification was Dean Leonard Mayo of W.R.U., with whom Donnell had a long conversation about his chairmanship of the Commission on Children and Youth. Dr. Mayo was interested only in the child welfare fund which the bill carried.

It appeared that the Commission on Children and Youth had been founded originally by the Children's Bureau of the Labor Department, and Donnell wondered whether the government connection should not have been plainer in the commission's literature and title. As to its change of title—"Had there been some criticism of the commission on grounds it was the organ of the Children's Bureau in lobbying affairs?" he asked. Mayo said no, there had been no such criticism and no lobbying.

"Well, was its function the influencing of legislation?"

"I would say not," answered Mayo. "I would say that its purposes and functions have been largely to bring together information with the hope that that information would so inform and equip competent and knowledgeable persons and groups that they might, on their own, take such steps as their wisdom and discretion indicated in providing more adequate services for children."

"Oh," said Senator Donnell.

ADVICE TO YOUNG RADIOLOGISTS

The American College of Radiology News Letter submits the following "memo to young radiologists beginning practice":

"It is frequently stated that young radiologists beginning practice after the completion of their training are compelled to accept full-time salaried positions with hospitals because they do not have sufficient funds to purchase the necessary equipment for a private office. This argument is untenable. Any properly qualified young radiologist with reasonably good references can obtain liberal credit from manufacturers of X-ray equipment."

To which might be added the observation that about the only things worthwhile in the long run are those which are obtained or achieved as a result of effort and sacrifice.

DEANS OF MEDICAL SCHOOLS PLEASE NOTE!

Courses in medical economics are now being given at Wayne University, Detroit, and at the University of Michigan, Ann Arbor, with the cooperation of the Michigan State Medical Society. Lectures cover such topics as voluntary prepayment plans, rural practice, services to veterans, public relations, medical organization activities, legislation, etc.

Tutoring the lads on such matters before turning them out into the cold, cruel world is something which has been too slow in coming. Quiz some of them on such matters if you doubt this statement.

Ohio need not be backward about copying from Michigan. Something like this is needed

PALATABILITY AND NUTRITION FACTORS



of

Campbell's STRAINED BABY SOUPS

Q. What is the importance of palatability?

A. A leading pediatrician has pointed out that even in the early months of life infants are able to detect minute differences in flavor. The appealing palatability of Campbell's Strained Baby Soups is, therefore, an advantage. It should further be pointed out that all the "tastes" in these soups are the wholly natural ones of the meats, vegetables and cereals used.

Q. Why are the different ingredients selected?

A. Campbell's Strained Baby Soups are planned to provide a balance in nutrients to supplement the daily milk diet. Since it takes many different foods to supply the approximately 40 nutrients needed for infant development and energy, we use vegetables and a cereal in preparing each of the four meat soups. Flavor is improved, too. For instance, liver alone has too strong a taste for some babies, but blended with vegetables, palatability is enhanced. It should also be noted that these soups are intended for use as early in normal infancy as any other strained baby foods.

Q. What measures are taken to conserve food constituents?

A. In preparing these Baby Soups, Campbell's have developed a method, based on the latest scientific knowledge, which retains the minerals and efficiently conserves the vitamins.

A comprehensive analysis of each soup may be had upon request to Campbell Soup Company, Camden, New Jersey.

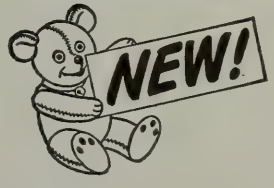
5 KINDS:

CHICKEN
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All in Glass Jars



Campbell's Strained Baby Soups represent fine quality . . . in ingredients . . . in care and method of cooking . . . in retention of minerals and conservation of vitamins . . . *and in good flavor.* Every resource of Campbell's Kitchens is devoted to that aim.



LOOK FOR THE RED-AND-WHITE LABEL

in Ohio. What do you say, deans? Maybe you are giving some courses like these now. If so, keep it up; expand them. If you're not, how about starting this Fall?

NOT A SIDESHOW BUT THE REAL McCOY

The official bulletin of the Jackson County (Missouri) Medical Society says that it presumes one of the reasons the Hon. Roger Slaughter was "purged" with the help of President Truman is because he had violently and consistently opposed the W-M-D Bill and similar social legislation proposed by the White House.

This is further evidence that the scrap on nationalization of medical care is not a sideshow but the real McCoy.

That being the case, it behooves all citizens who think "statism" distasteful to inquire as to just how the candidates for Congress feel about the Wagner-Murray-Dingell proposal.

Talk this over with your neighbors and friends in business, industry, and other professions. Let them know that they have just as much of a stake in the outcome of the battle on the W-M-D measure as you, as a physician, have—maybe more.

Too many persons think that this issue is of no concern to anyone much but "the doctors". It's time they are learning that all the people had better be concerned. The outcome of this argument will set the pattern for many other ideas which "the planners" are waiting to propose.

HOSPITAL FACILITIES NEEDED? WHY AND WHERE?

During the past few months, the Columbus Headquarters Office has received almost a score of requests from physicians, medical society officers, or civic leaders for information and advice on how to go about it to organize a movement for the erection of a new hospital or expansion of an existing institution. Available material, which is not too extensive, has been supplied.

In our opinion, this poses a serious question which deserves a lot more study than has been given to it by many of those who, in their enthusiasm, think that it is a very simple matter to raise funds for a hospital, build the hospital, equip it, staff it, and maintain it.

Admittedly there are areas in Ohio which should have a hospital. Where are those areas?

There are communities in Ohio which feel they should have a hospital. Do they need one? Could they support one?

There is a lot of horse sense in recent comments made by *Modern Hospital,* referring to a report based on interviews with a number of hospital leaders on the shortage of hospital facilities and ways to meet this problem. To quote:

"Yet the report also reveals that many hospital leaders are hesitant about pushing building plans, even in the face of excessive demands apparently resulting from stable as opposed to temporary factors.

"Probably this hesitancy reflects in part the fact that hospitals are having a hard time finding enough employees to staff present plants, let alone additions, and in part, too, the uncomfortable feeling that this is a time for watchful conservatism.

"Whatever its origins, this restraint is wholesome to the extent that it may prevent hospitals from embarking on building projects simply because the money is at hand or can be obtained and there are patients clamoring at the door.

"More and more, hospitals are seeking expert help in evaluating the long term need for hospital facilities and integrating their plans with those of other health agencies in the community. With all its discouraging implications, the present report includes hopeful signs that a great weakness of our hospital structure, arising from the tendency for hospitals to be built where somebody has the money to build them instead of where they are really needed, may be avoided in the expansion period that lies ahead."

Ohio cities and counties should not go off half cocked on this matter. They should look, and look well, before they leap.

A real honest-to-gosh study of hospital facilities and needs in Ohio is a "must". Unless this is done, mistakes—bad ones—will be made.

Building and maintenance of hospitals is big business. A scientific approach to the project is the only correct approach.

KAADT INSTITUTE AGAIN UNDER FIRE

The Indianapolis Better Business Bureau has filed a petition with the Indiana State Board of Medical Registration and Examination, asking for revocation of the license of Dr. Charles Kaadt, operator of the Kaadt Diabetic Institute, South Whitley, Indiana. The action followed investigations of the "special treatments" used at the institution and a follow-up study of patients who had been treated there, some of whom died following their return home. The "institute" is alleged to offer a "cure" for diabetes in three days through a special treatment which does not include the administration of insulin.

Kaadt's advertisements have been circulated in Ohio. The record shows that he has been exposed on several occasions by the American Medical Association and that he has been in bad with the Post Office Department with respect to the wording of his blurbs.

Here's hoping the new evidence stands up under fire.

FALL GRADUATE INSTRUCTIONAL COURSE IN ALLERGY

THE AMERICAN COLLEGE OF ALLERGISTS

JEFFERSON MEDICAL COLLEGE, PHILADELPHIA • NOVEMBER 4-9, INCLUSIVE

SCHEDULE OF SUBJECTS AND FACULTY

Monday, November 4

A.M. *Fundamentals of Allergy*

8:00- 9:00 Registration

9:00- 9:10 Address of Welcome
WILLIAM HARVEY PERKINS, M.D., Dean, Jefferson Medical College, Philadelphia.

9:10-10:00 Role of Histamine in Allergy
HAROLD A. ABRAMSON, M.D., Columbia Univ.

10:00-11:30 Physiological Aspects of Allergy
CHARLES F. CODE, M.D., Mayo Clinic

11:30-12:30 Pathology of Allergy
MORTON MCCUTCHEON, M.D., University of Pennsylvania School of Medicine, Philadelphia.

12:30-12:45 Orientation
GEORGE E. ROCKWELL, M.D., Chairman

P.M. *Fundamentals of Allergy and Therapy*

2:00- 3:00 Immuno-Chemical Aspects of Allergy
FRED W. WITTICH, M.D., Minneapolis, Minn.

3:00- 4:00 Anti-Histamine acting Substances
RALPH L. MAYER, M.D., Chief Bacteriologist, Ciba Pharmaceutical Products

4:00- 6:00 Clinical Use of Histamine
BAYARD T. HORTON, M.D., Mayo Clinic

7:30 Informal Dinner
Speaker: LEON UNGER, M.D., President, American College of Allergists
Subject: *Opportunities and Pitfalls in Allergy*

Tuesday, November 5

A.M. *Therapy*

9:00- 9:45 X-ray Value in Allergy; Diagnosis, Treatment
PAUL C. SWENSON, M.D., Professor of Radiology, Jefferson Med. College, Philadelphia

9:45-10:30 Medical Emergencies in Allergy
J. WARRICK THOMAS, M.D., Graham-Thomas Clinic, Richmond, Va.

10:30-11:00 Anti-biotics in Allergy
HOBART REIMANN, M.D., Professor of Medicine, Jefferson Medical College, Philadelphia

11:00-11:30 Vaccines: Their Preparation and Use
GEORGE E. ROCKWELL, M.D., Milford, Ohio

11:30- 1:00 Materia Medica and Pharmacology of Drugs Used in Allergy
ETHAN ALLAN BROWN, M.D., Tufts

P.M. *Special Allergies*

2:00- 3:00 Bacterial Allergy
M. SCHERAGO, Professor of Bacteriology, University of Kentucky, Lexington, Kentucky

3:00- 3:30 Mold Allergy: Pathogenic Molds
FRED W. WITTICH, M.D., Minneapolis, Minn.

3:30- 4:30 Allergy from Drug and Biological Products
BRET RATNER, M.D., New York University

4:30- 5:30 Physical Allergy
CECIL KOHN, M.D., Kansas City, Missouri

Wednesday, November 6

A.M. *Respiratory Allergy*

9:00-10:00 Allergic Rhinitis
FRENCH K. HANSEL, M.D., Washington Univ.

10:00-11:00 Allergic Bronchitis, Bronchiectasis, and Loeffler's Syndrome
J. WARRICK THOMAS, M.D., Graham-Thomas Clinic, Richmond, Va.

11:00-12:30 Bronchial Asthma
HARRY L. ROGERS, M.D., Jefferson Med. College

12:30- 1:00 Bronchoscopy in the Treatment of Asthma
LOUIS CLERF, M.D., Jefferson Medical College

P.M. *Respiratory Allergy* (continued)

2:00- 3:00 Inhalation Therapy of Asthma
ALVAN L. BARACH, M.D., Columbia University College of Physicians and Surgeons, New York

3:00- 3:45 Cardiac Asthma
LEON UNGER, M.D., N. W. Univ. Med. School

3:45- 4:30 Status Asthmaticus
HAL DAVISON, M.D., Emory Univ., Atlanta

4:30- 6:00 Bronchial Asthma in Infants and Children
M. MURRAY PESHKIN, M.D., Columbia Uni. Coll. of Physicians and Surgeons, New York

Thursday, November 7

A.M. *Dermatologic Allergy*

9:00-10:00 Dermatologic Allergy in Children
JEROME GLASER, M.D., University of Rochester Medical School, Rochester, New York

10:00-11:00 Atopic Dermatitis
STEPHAN EPSTEIN, M.D., Marshfield Clinic, Marshfield, Wisconsin

11:00-12:00 Contact Dermatitis
RUDOLPH BAER, M.D., New York Post Graduate Med. School of Columbia Univ., New York

12:00-12:45 Urticaria
JONATHAN FORMAN, M.D., Ohio State University Medical School, Columbus

12:45- 1:15 Poison Ivy
LAWRENCE J. HALPIN, M.D., Cedar Rapids

P.M. *Concurrent Laboratory and Clinical Sessions*
Listed on bottom of page

Friday, November 8

A.M. *Hay Fever*

9:00- 9:30 Botany
ROGER WODEHOUSE, Ph.D., Associate Director of Research in Allergy, Lederle Laboratories

9:30-11:00 Diagnosis and Treatment of Hay Fever
MERLE MOORE, M.D., University of Oregon Medical School, Portland

11:00-11:30 Chemical Nature of the Pollen Antigen and the Types of Extracts Used. GEORGE E. ROCKWELL, M.D., Milford

11:30-12:30 Immunology of Hay Fever: Perennial and Booster Dose Therapy. MARY LOVELESS, M.D., Cornell University Medical College

12:30- 1:00 Low Dosage Therapy
FRENCH K. HANSEL, M.D., Washington Univ.

P.M. *Special Allergies*

2:00- 3.30 Food Allergy
ORVAL R. WITHERS, M.D., University of Kansas School of Medicine, Kansas City

3:30- 4:00 Méinère's Disease
BAYARD T. HORTON, M.D., Mayo Clinic

4:00- 4:45 Migraine
FOSTER KENNEDY, M.D., Cornell University Medical College, New York

4:45- 5:30 Ocular Allergy
A. R. RUEDEMAN, M.D., C'eveland Clinic,

5:30- 6:15 Epilepsy
T. WOOD CLARKE, M.D., Utica, New York

Saturday, November 9

A.M. *Special Allergies*

9:00- 9:45 Reactions to blood transfusions and Blood Dyscrasia due to Allergy. HAROLD W. JONES, M.D., Philadelphia

9:45-10:15 Joint Allergy
BELA SCHICK, M.D., New York

10:15-10:45 Aural Allergy
HUGH KUHN, M.D., Hammond, Indiana

10:45-11:15 Common Air Molds and Their Relation to Allergy. HOMER PRINCE, M.D., Baylor University Medical School, Houston, Texas

11:15-11:45 Shock Therapy in Allergy
GEORGE E. ROCKWELL, M.D., Milford, Ohio

11:45- 1:00 Office Management
HOMER PRINCE, M.D., Baylor University Medical Schcol, Houston, Texas

1:30 Luncheon
Round Table Discussion

Laboratory Session	*Pediatrics*	*Asthma Clinic*	*Hay Fever Clinic*	*Dermatology Clinic*	*Neuro-Allergy*
Skin tests Patch tests Passive transfer Nasal smears Molds Extraction methods Standardization	Special problems in asthma, hay fever, dermatitis	ROGERS UNGER DAVISON BARACH CLERF	MOORE LOVELESS WODEHOUSE	EPSTEIN BAER FORMAN HALPIN	Movies HORTON Clinic KENNEDY CLARKE
UNGER PRINCE HANSEL HALPIN WITTICH ROCKWELL	PESHKIN GLASER				

The fee for the course is $100 payable at the registration desk, Jefferson Medical College Building, Philadelphia, Pennsylvania. Headquarters is at the Benjamin Franklin Hotel. (For those in, or out of Service six months or less prior to the course, fee is $25.) Applications for the course and for hotel reservations should be placed with the Secretary, American College of Allgerists, 423 La Salle Medical Building, Minneapolis 2, Minnesota.

O. S. M. A. HAS EXHIBIT AT STATE FAIR



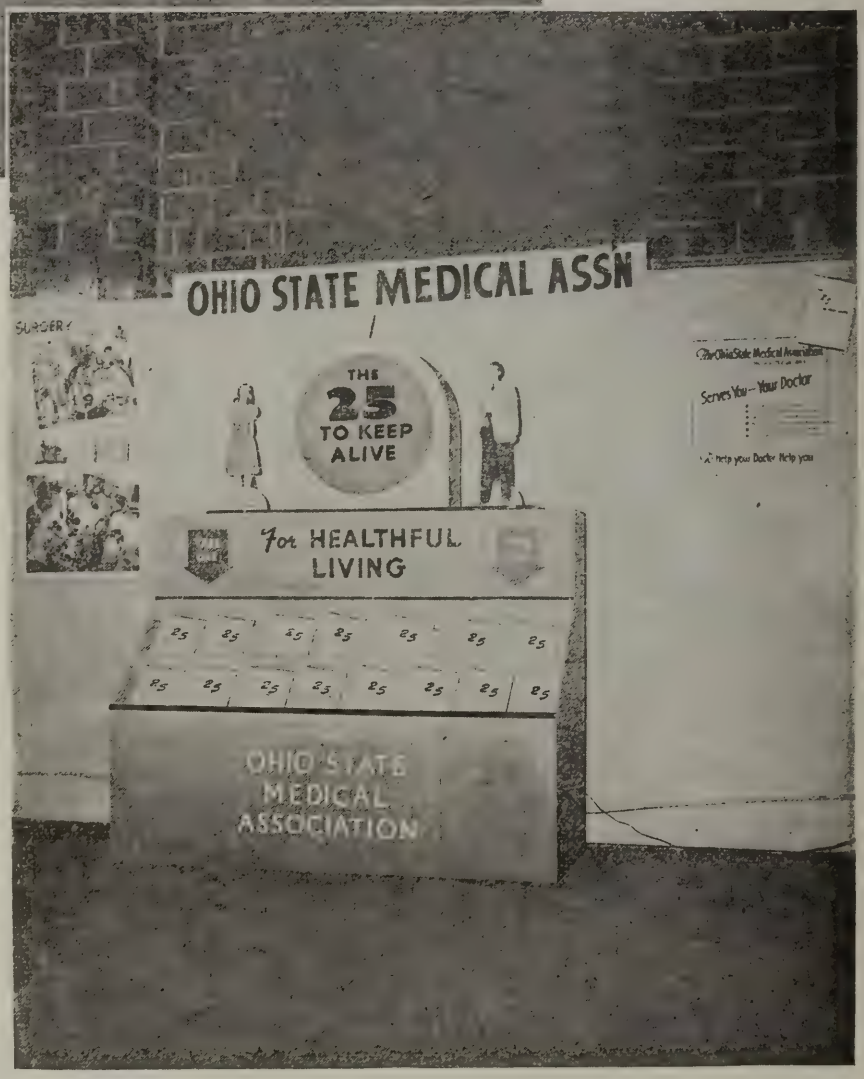
MORE than 17,000 copies of the Ohio State Medical Association's booklet *"The 25 to Keep Alive"* were distributed from the exhibit booth of the Association at the Ohio State Fair, August 24-30.

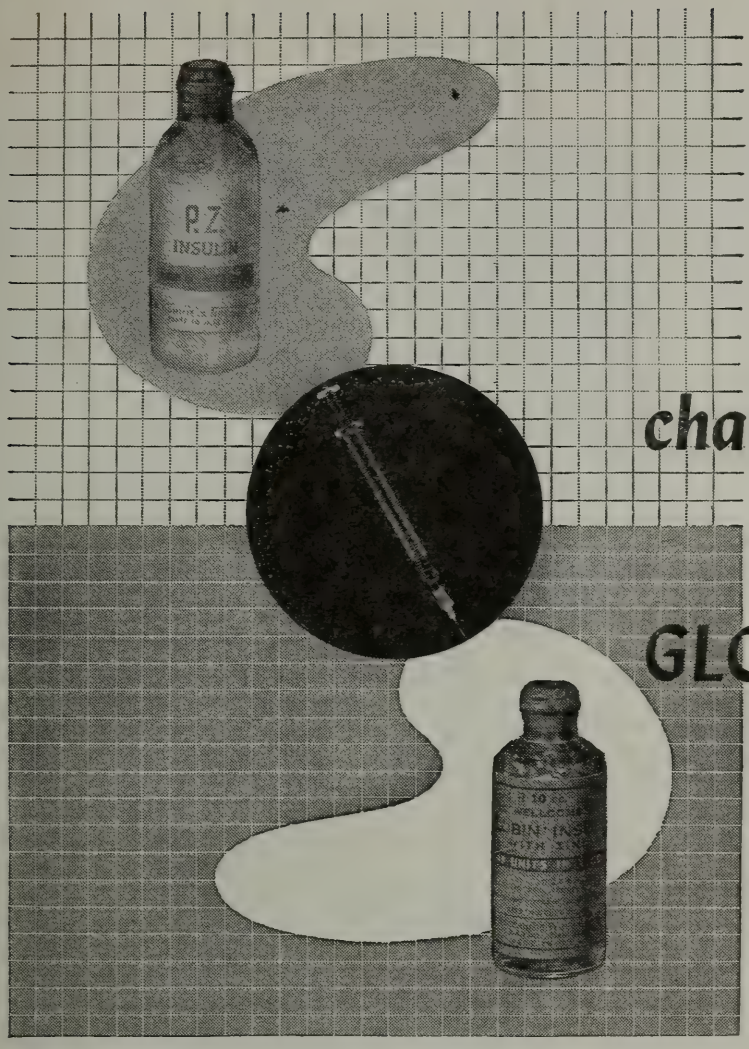
The booklet contains the 25-point health program for the state of Ohio as adopted by the House of Delegates of the Association during the Centennial Anniversary meeting in May.

Attention was called to the booklet by a flashing light display sign from which arrows pointed to shelves containing a number of copies, as pictured lower right.

On the walls of the booth, which covered a 30-foot frontage at the southeast corner of the State Exhibit Building, appeared the 16-panel "Century of Progress in Medicine" display, which was a feature of the centennial anniversary meeting of the Association.

Besides members of the Bureau of Public Relations staff, four Ohio State University junior medical students were on hand to explain various features of the booklet and the display. These students were Jack Ashcraft, Robert Lanfersieck, Stanley Jacob, and Paul Mori. Mori and Jacob appear in the picture, upper left, discussing *"The 25 to Keep Alive"* with fair visitors.





changing from PZI to GLOBIN INSULIN

When protamine zinc insulin treatment is complicated by post-prandial hyperglycemia, nocturnal insulin reaction, protamine sensitivity, or other difficulties, a change to Globin Insulin often results in the desired improvement. The change is achieved in three steps:

1. THE INITIAL CHANGE-OVER DOSAGE: The first day, 30 minutes or more before breakfast, give a single dose of Globin Insulin, equal to ½ the total previous daily dose of protamine zinc insulin or of protamine zinc insulin combined with regular insulin. The next day, dose may be increased to ⅔ former total.

2. ADJUSTMENT TO 24-HOUR CONTROL: Gradually adjust the Globin Insulin dosage to provide 24-hour control as evidenced by a fasting blood sugar level of less than 150 mgm. or sugar-free urine in the fasting sample.

3. ADJUSTMENT OF DIET: Simultaneously adjust carbohydrate distribution of diet to balance insulin activity; initially 2/10, 4/10 and 4/10. Any midafternoon hypoglycemia may usually be offset by 10 to 20 grams carbohydrate at 3 to 4 p.m. Base final carbohydrate adjustment on fractional urinalyses.

Most mild and many moderately severe cases may be controlled by *one daily injection of 'Wellcome' Globin Insulin with Zinc.* Vials of 10 cc.; 40 and 80 units per cc. Developed in The Wellcome Research Laboratories, Tuckahoe, New York. U.S. Pat. 2,161,198. Literature on request.

'Wellcome' Trademark Registered

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Mutual Responsibilities of Medical Profession and Health Departments Discussed by Dr. McNamee at Conference

THE health of the citizens of Ohio is the mutual responsibility of the health departments and the private practitioners of medicine of the state, Dr. E. P. McNamee, Cleveland, president of the Ohio State Medical Association, pointed out in an address to the 27th Annual Conference of the Health Commissioners of Ohio with the Ohio Department of Health, held September 5 and 6 in Columbus.

Describing the role of the medical profession in dealing with health problems, Dr. McNamee told of the "Twenty-Five Point Health Program for Ohio" as adopted by the House of Delegates of the Association during the centennial anniversary meeting in May, a program which is receiving the consideration of health-minded organizations throughout the state.

CITES PREPAYMENT PLAN

Dr. McNamee also mentioned Ohio Medical Indemnity, Inc., the "Doctors' Plan" which offers medical prepayment service to supplement Blue Cross hospitalization. Moreover, he stated that the Association's Committee on Rural Health is investigating the problem of supplying more adequate health facilities to rural areas and small communities.

The lack of sanitary milk regulations in 19 per cent of the cities and 47 per cent of the counties of the state was deplored by Dr. McNamee, who also charged that laws to prevent stream and lake pollution are not being enforced.

A state-wide coordinated program of cancer control; a minimum of 1,500 more tuberculosis hospital beds and X-ray screen tests for tuberculosis control; and a 100 per cent increase in the number of general hospital beds to bring the total to about 90,000, were other recommendations of Dr. McNamee.

FEWER HEALTH UNITS URGED

He also endorsed the reorganization of the health units of the state according to the pattern outlined by Dr. Haven Emerson (also a speaker at the conference), chairman of a committee of the American Public Health Association, which issued the report, *Local Health Units for the Nation.*

Dr. Emerson in his address said that one-third of the people of Ohio are not receiving adequate health protection with the present organization of local health jurisdictions. Following closely the recommendations of his report, he suggested reallocation of health units, reducing the present 203 to 53, and for increased expenditures by the state in maintaining high standards of operation.

Each of the proposed 53 units would be under a full-time doctor of medicine, trained in public health, with a salary approximating that of the net income of a surgeon or internist of the given area, if Dr. Emerson's recommendations were followed.

Dr. Emerson emphasized the fact that public health is a matter of preventing disease, and that diagnosis and treatment of the disease itself is a personal responsibility and the work of the physician.

Estimated cost of administering the suggested plan in Ohio is about $6,638,000 or a per capita of about 96 cents. The 1942 cost of Ohio's public health system was $4,009,100, a per capita of 58 cents. Increased prices have brought the present per capita cost to about 78 cents.

"Ohio, as tenth among all states in spendable income, can surely absorb the cost of basic minimum local health service from its own sources of public revenue," he continued. He said that one-third of the people are living in communities where no professionally directed health services are provided, and that part-time health officers can not provide adequate medical care in their districts.

An abstract of the Commonwealth Fund report with details as to how the 53 units would be organized appeared on page 788, July issue, *The Ohio State Medical Journal.*

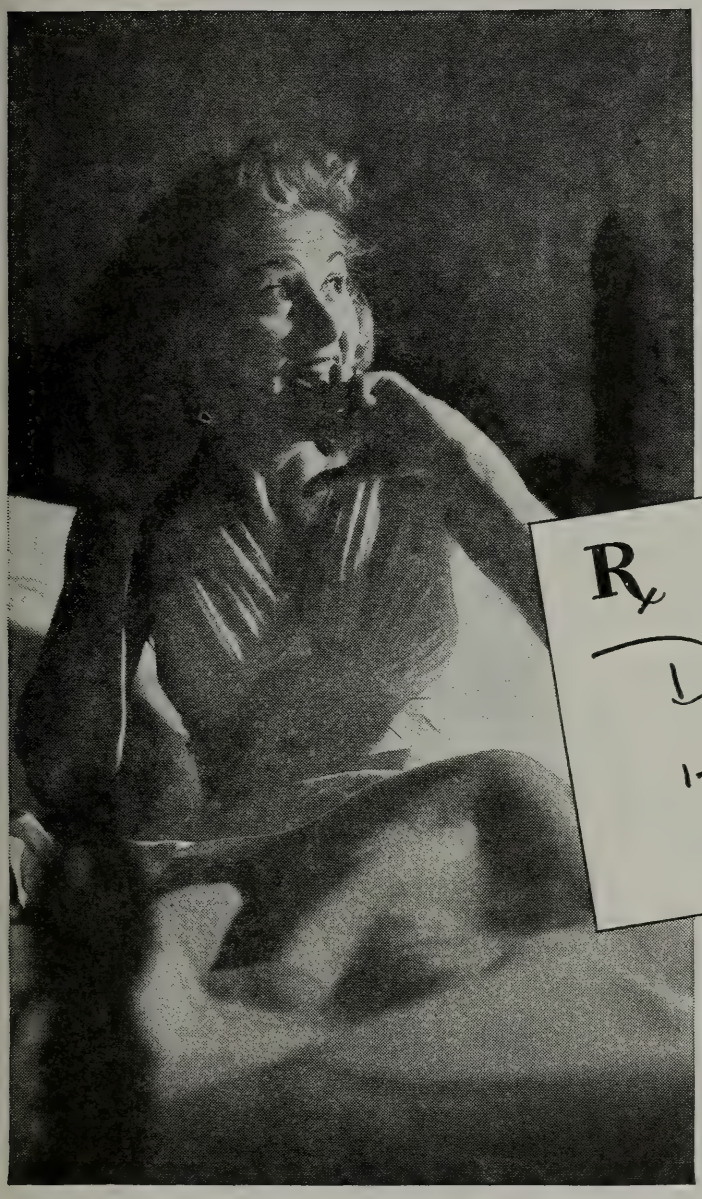
OTHER SPEAKERS

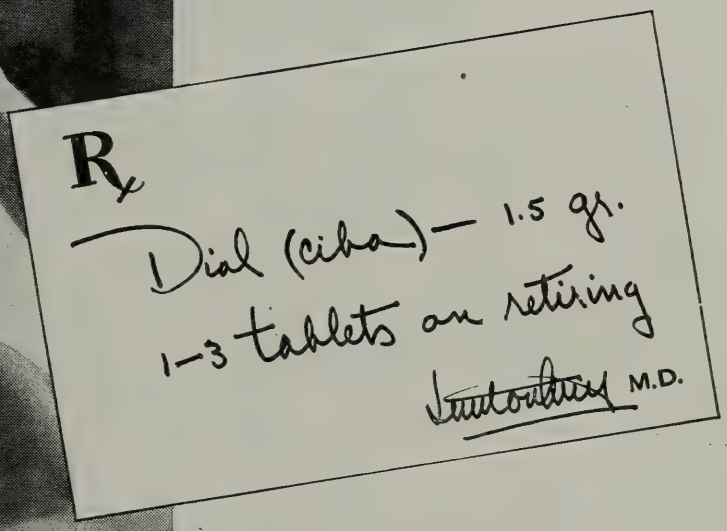
Other speakers at the conference, at which State Director of Health Roger E. Heering presided, included Walter Snyder, University of Michigan School of Public Health, speaking on "The Sanitation Foundation, Its Organization, Purpose, and Activities"; Dr. Carl A. Wilzbach, Commissioner of Health, Cincinnati, "Purpose and Progress of the Governor's Committee on Tuberculosis Control"; Dr. Attilio Laguardia, assistant commissioner, division of mental hygiene, Ohio Department of Public Welfare, and Dr. Paul C. Clark, clinical director, Columbus State Hospital, "Shock Therapy in the Management of the Mentally Ill".

A. J. Borowski, D.P.H., registrar and superintendent, Bureau of Vital Statistics, Toledo Board of Health, read a paper on "The Value of Vital Statistics to the Health Department and Staff Members".

A paper on "Histoplasmosis", prepared by Dr. Charles A. Doan, dean of the Ohio State University College of Medicine, was read by Dr. Claude Starr Wright of the medical school faculty.

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This effective sedative and hypnotic will induce peaceful sleep. Dial may be taken during working hours in moderate dose when sedation is required.

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RETURN TO CIVILIAN LIFE AFTER MILITARY SERVICE

FOLLOWING are the names of additional Ohio physicians who have been released from military service or have started terminal leave, according to information received recently by *The Journal*. The rank shown is based on the most recent data in the files of the Ohio State Medical Association:

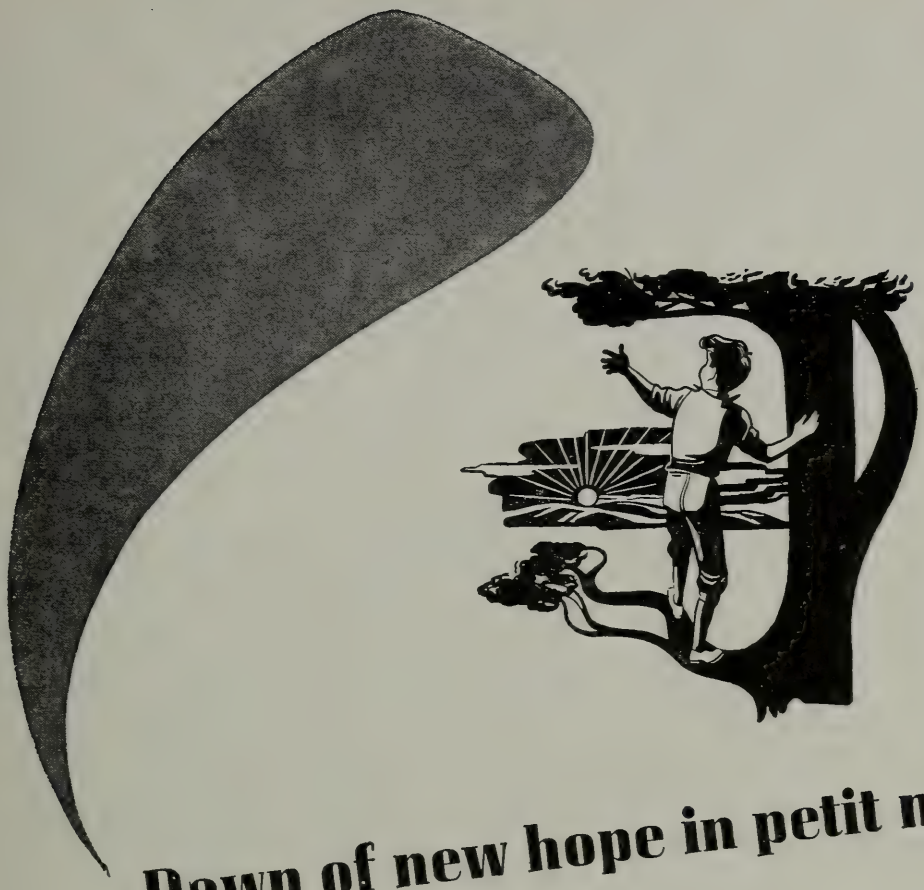
Name	City	Rank
Abrams, Nathan R.	Cincinnati	Capt., A.U.S.
Armstrong, Charles B.	Cincinnati	Capt., A.U.S.
Bartlett, Robert M.	Akron	Major, A.U.S.
Basnett, Carl M.	Columbus	Major, A.U.S.
Beach, Douglas	Bellefontaine (formerly of Dayton)	1st Lt., A.U.S.
Beckerman, Samuel	Cleveland	Capt., A.U.S.
Beery, Walter C.	Lima	Major, A.U.S.
Berg, Robert William	Cleveland	Capt., A.U.S.
Bernard, C. Henry	Akron (formerly of Cleveland)	Lt. Col., A.U.S.
Berry, Jack J.	Cleveland	Capt., A.U.S.
Beynon, David E.	Girard	Capt., A.U.S.
Biles, Robert A.	Cincinnati	Capt., A.U.S.
Bilton, Joseph L.	Cleveland	Lt. Comdr., U.S.N.R.
Bobey, Milton E.	Cleveland	Capt., A.U.S.
Brady, Richard M.	Akron	Major, A.U.S.
Breneman, Roscoe H.	Akron	Capt., A.U.S.
Brown, Charles G.	Mansfield	Capt., A.U.S.
Brown, John A.	Morristown	Capt., A.U.S.
Bruce, Robert A.	Dayton	Capt., A.U.S.
Bubna, Louis E.	Cleveland	Capt., A.U.S.
Burrows, John W.	Berea	Capt., A.U.S.
Cameron, James E.	Defiance	Major, A.U.S.
Catalano, Anthony C.	Cleveland	Capt., A.U.S.
Coffin, Theodore A.	Kansas City, Missouri (formerly of Painesville)	Major, A.U.S.
Cole, Allan A.	Logan	Lt. Col., A.U.S.
Cramer, Irving I.	Cleveland	Major, A.U.S.
Cranston, Clyde J.	Wakeman	Lt. Col., A.U.S.
Crist, J. O.	Centerburg	Lt. Col., A.U.S.
Crosby, Frank D.	Bellevue	Capt., A.U.S.
Dalton, William J.	Columbus (formerly of Cincinnati)	Capt., A.U.S.
Duey, John O.	Beaver Falls, Pa. (formerly of East Cleveland)	Lt. (jg), U.S.N.R.
Fargotstein, Ralph	Springfield	Lt. (jg), U.S.N.R.
Fee, Charles H.	Columbus	Capt., A.U.S.
Fergus, Joseph A.	St. Paris	Major, A.U.S.
Fineberg, Meyer H.	Dwight, Illinois (formerly of Cleveland)	Col., A.U.S.
Finke, Frederick C.	Columbus	Capt., A.U.S.
Fish, John S.	Cleveland	Capt., A.U.S.
Frank, Herbert	Cleveland (formerly of Ravenna)	Capt., A.U.S.
Geyer, Joseph H.	Columbus	Major, A.U.S.
Goldman, Frederick M.	Cincinnati	Lt., U.S.N.R.
Greene, George J.	Cleveland	Lt. Comdr., U.S.N.R.
Hamilton, Paul V.	Cincinnati	Lt. Col., A.U.S.
Harsha, James M.	Miami, Florida (formerly of Washington C. H.)	Lt. Col., A.U.S.
Haydon, George B.	Cincinnati	Major, A.U.S.
Hazel, Woodrow S.	Youngstown	Capt., A.U.S.
Henry, Robert J.	Columbus	Lt. (jg), U.S.N.R.
Hill, Willard T.	Cleveland (formerly of Ashtabula)	Capt., A.U.S.
Ivins, Paul N.	Hamilton	Lt. Col., A.U.S.
Jones, Mason Scott	Columbus	Capt., A.U.S.
Kahn, Joseph R.	Cleveland	Major, A.U.S.
Kahn, Raymond M.	Dayton	Capt., A.U.S.
Kessler, Dale L.	Camden (formerly of Cincinnati)	Capt., A.U.S.
King, Douglass S.	Alliance	Major, A.U.S.
Leach, Joseph T.	Columbus	Lt. (jg), U.S.N.R.
Lehmiller, Karl L.	North Industry	Major, A.U.S.
Leslie, Roland A.	Cincinnati	Capt., A.U.S.
Maltby, George L.	Portland, Maine (formerly of Cincinnati)	Major, A.U.S.
Margolis, Meyer N.	Cincinnati	Capt, A.U.S.
Matson, John W.	Los Angeles, Calif. (formerly of Uhrichsville)	Lt. Col., A.U.S.
McFadden, Harry W.	Pittsburgh, Pa. (formerly of Brecksville)	Lt. Col., A.U.S.
McNerney, N. H.	Cleveland	Col., A.U.S.
Miller, James D.	Youngstown	Capt., A.U.S.
Minelli, Anthony J.	Cleveland	Lt., U.S.N.R.
Moon, Richard P.	Dayton	Capt., A.U.S.
Moorman, Thomas A.	St. Louis, Missouri (formerly of Dayton)	Capt., A.U.S.
Mosher, Henry A.	Boston, Massachusetts (formerly of Dayton)	Major, A.U.S.
Mowry, Robert S.	Palo Alto, California (formerly of Lima)	Major, A.U.S.
Neese, John O.	Royal Oak, Michigan (formerly of Mt. Victory)	Capt., A.U.S.
Nellins, Donald C.	Cleveland	Capt., A.U.S.
O'Hare, James E.	Cleveland	Capt., A.U.S.
Pliskin, Reuben R.	Akron	Lt. Col., A.U.S.
Ralston, John F.	Cleveland	Capt., U.S.N.R.
Searl, Howard A.	Cuyahoga Falls	Capt., A.U.S.
Shipley, Thomas	Rochester, New York (formerly of Canton)	Capt., A.U.S.
Slasor, William J.	Massillon (formerly of Toledo)	Major, A.U.S.
Smith, Paul Edward E.	Canton	Major, A.U.S.
Smith, Thomas L.	Lorain	Lt., U.S.N.R.
Soloway, Lewis R.	Cleveland	Capt., A.U.S.
Stahl, R. H.	Cuyahoga Falls (formerly of Akron)	Capt., A.U.S.
Stephens, James T.	Oberlin	Major, A.U.S.
Stoll, Richard G.	Cleveland	1st Lt., A.U.S.
Storer, William E.	Middletown	Capt., A.U.S.
Talbot, David R.	Los Angeles, Calif. (formerly of Mansfield)	Comdr., U.S.N.R.
Troup, Paul	Dayton	Major, A.U.S.
Ulrich, Robert P.	Cincinnati (formerly of Orrville)	Capt., A.U.S.
Vande Velde, Joseph D.	Cleveland	Major, A.U.S.
Volpe, Peter A.	Columbus	Major, A.U.S.
Wales, Craig C.	Youngstown	Major, A.U.S.
Wilson, Stewart M.	Kansas City, Missouri (formerly of Columbus)	Capt., A.U.S.
Wentsler, Norman E.	Akron	Lt., U.S.N.R.
Woodruff, John R.	Englewood	Col., A.U.S.
Woolpert, Oram C.	Frederick, Maryland (formerly of Columbus)	Col., A.U.S.
Wright, Norman S.	Springfield	Capt., A.U.S.
Yurick, Edward A.	Cleveland	Major, A.U.S.

Military News Notes

On page 878 of the August issue of *The Journal*, it was incorrectly noted that "Col. Arthur H. King, Alliance," had been awarded the Bronze Star Medal. Actually, the award was made to "Col. Arthur G. King, Cincinnati," who served in the Medical Corps of the Army of the United States from Aug. 4, 1941, to April 18, 1946. Occupying one of the top administrative positions overseas, Col. King was Surgeon of the Service Command at New Caledonia and later at Espiritu Santo. This involved supervision of a total of eight hospitals, including for a short period the Fourth General Hospital, the Cleveland Lakeside Hospital unit, before it was detached and assigned to General MacArthur.

The citation for the Bronze Star Medal awarded Col. King reads as follows:

"For meritorious service in connection with military operations against the enemy from 12 November 1942 to 22 November 1943. As Surgeon of the Service Command at New Caledonia and later at Espiritu Santo, he organized the Surgeon's Office at the time of the activation of the Service Command at each of these places and displayed outstanding ability in the subsequent coordination of all medical activities



Dawn of new hope in petit mal . . .

New hope for thousands of children languishing under the social and educational handicaps imposed by petit mal is offered by Tridione, a product of Abbott research which has been proved effective in the treatment of numerous petit mal cases *in which other forms of medication were unsuccessful.* For example, in one group of 50 patients subject to frequent petit mal, myoclonic or akinetic seizures not helped by previous treatment, Tridione eliminated the seizures in 28 percent, reduced them to less than one-fourth of the usual number in 52 percent, and caused little or no change in 20 percent.[1] In several cases the seizures once stopped *did not return* when medication was discontinued. Tridione also has been of value in the treatment of certain psychomotor cases when used in combination with other medication.[2] You may obtain Tridione in 0.3-Gm. capsules in bottles of 100 and 1000. If you wish literature on Tridione, we shall be pleased to send it to you. ABBOTT LABORATORIES, North Chicago, Illinois.

Tridione

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(3,5,5-TRIMETHYLOXAZOLIDINE-2,4-DIONE, ABBOTT)

1. Lennox, W. G. (1945), Petit Mal Epilepsies: Their Treatment with Tridione, J. Amer. Med. Assn., 129:1069, December 15.
2. DeJong, R. N. (1946), Effect of Tridione in the Control of Psychomotor Attacks, J. Amer. Med. Assn., 130:565, March 2.

and sanitation on each Island. His sound technical advice was invaluable during the construction of two hospitals, and the positive measures instituted to insure that all military personnel observed rules of sanitation contributed materially to effective malaria control and to the reduction of the sick rate with consequent increase in the morale of troops. The tireless energy, initiative, and devotion to duty displayed by Colonel King reflect great credit upon himself and upon the military service."

* * *

Lt. (j.g.) Sanford Glanz, Cleveland, is on duty at Guam with the 103rd Naval Construction Battalion.

Council and Advisory Board Named For Hospital Building Program

Formation of a Federal Hospital Council and an advisory committee to assist Surgeon General Thomas Parran of the U. S. Public Health Service in the administration of the Hill-Burton Hospital Survey and Construction Act has been announced by Federal Security Administrator Watson B. Miller.

The Federal Hospital Council is composed of the Surgeon General, who serves as chairman, ex-officio, and eight members appointed by the Federal Security Administrator. Four members are outstanding in health and hospital fields, and four are representatives of the consumers of hospital services.

Those members representing the hospital and health fields are: Dr. Albert W. Dent, President, Dillard University, New Orleans, La.; Very Reverend Monsignor John J. Bingham, Director, Division of Health, Catholic Charities, New York City; Mr. Graham Davis, Director of Hospitals, Kellogg Foundation, Battle Creek, Michigan; Dr. Robin C. Buerki, Dean, Graduate School of Medicine, University of Pennsylvania, Philadelphia, Pa.

Council members representing the consumers of medical services include Dr. Michael M. Davis, Committee for the Nation's Health, New York, N. Y.; Honorable J. Melville Broughton, Attorney-at-Law, Raleigh, N. C.; Mrs. Evelyn Hicks, Radio Station WTNB, Birmingham, Ala.; Mr. Clinton S. Golden, United Steel Workers of America, Pittsburgh, Pa.

Mr. Miller pointed out that the Federal Hospital Council is unique in that the Hospital Survey and Construction Act vests it with certain administrative functions. These include the approval of general regulations under which the program will operate—an unusual responsibility for a council of this type.

Members of the Advisory Committee will serve as consultants to the Surgeon General and the Federal Hospital Council, in the administration of the Hospital Survey and Construction Act. To obtain the benefit of as wide representation as possible on the Advisory Committee its membership will be extended as specific needs arise.

With the approval of the Federal Security Administrator, Doctor Parran has issued invitations to serve on this Committee to the following: Claude Munger, M.D., Superintendent, St. Luke's Hospital, New York City; Arthur Bachmeyer, M.D., Director, University of Chicago Clinics and Hospitals, Chicago; Henry Southmayd, Director, Hospital Activities, Commonwealth Fund, New York City;

Victor Johnson, M.D., Secretary, Council on Education and Hospitals, American Medical Association, Chicago; Everett Jones, Vice-President, Modern Hospital Publishing Company, Chicago; George Bugbee, Executive Director, American Hospital Association, Chicago; Anthony J. J. Rourke, M.D., Director, Stanford University Hospitals, San Francisco; Arthur Will, Director of Charities, Los Angeles Co., Los Angeles, Calif.; **Joseph W. Fichter, Master, Ohio State Grange, Columbus, Ohio;** Stanley A. Pressler, Associate Professor of Accounting, Indiana University School of Business, Bloomington, Indiana; James R. Edmunds, Architect, President, American Institute of Architects, Baltimore, Maryland; Ranson E. Aldrich, American Farm Bureau Federation, Cleveland, Miss.; Nelson Cruikshank, Director, Social Insurance Activities, American Federation of Labor, Washington, D. C.; James A. Hamilton, Hospital Consultant, Yale University, New Haven, Conn.; Rev. A. N. Schwitalla, President, Catholic Hospital Association and Editor, Hospital Progress, Milwaukee, Wisc.; Miss Erma Holtzhausen, Director of Nursing Services, Vanderbilt University Hospital, Nashville, Tenn.; Mrs. Agnes Meyer, Washington, D. C.; Dr. Carl W. Waldron, Dean, School of Dentistry, University of Minnesota, Minneapolis, Minnesota;

Dr. Frank P. Tallman, Commissioner of Mental Diseases, State of Ohio, Columbus, Ohio; Mr. Howard L. Russell, Director, American Public Welfare Association, Chicago; Miss Elisabeth Christman, Secretary-Treasurer, National Women's Trade Union League of America, Washington, D. C.; Dr. Franklin S. Crockett, Chairman, Committee on Rural Medical Service, American Medical Association, Lafayette, Indiana; Right Reverend Monsignor John O'Grady, Secretary, National Conference of Catholic Charities, Washington, D. C.; Mr. David V. Addy, Chairman, Child Welfare Committee, American Legion, Detroit, Mich.

A campaign to raise $2,500,000 to build a research center in Hot Springs, Arkansas, for studies of the causes and cures of arthritis has been launched by the National Arthritis Research Foundation, according to *New York Medicine.*



To restore nasal patency in colds and sinusitis . . .

Neo-Synephrine decongests promptly . . . clears the nasal airways for greater breathing comfort . . . promotes sinus drainage. Relief lasts for several hours. Virtual freedom from compensatory vasodilatation precludes development of dependency symptoms.

Neo-Synephrine

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For Nasal Decongestion

THERAPEUTIC APPRAISAL: Prompt, prolonged nasal decongestion without appreciable compensatory recongestion; virtual freedom from local and systemic side effects; sustained effectiveness on repeated use.

INDICATED for symptomatic relief of the nasal congestion of common colds, sinusitis and allergic rhinitis.



ADMINISTRATION may be by dropper, spray or tampon, using the ¼% in most cases, the 1% when a stronger solution is indicated.

SUPPLIED as ¼% and 1% in isotonic saline and ¼% in Ringer's with aromatics, bottles of 1 fl. oz.; ½% jelly in convenient applicator tubes, ⅝ oz.

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VETERANS' INQUIRY DEPARTMENT

Ohio Openings and Locations Sought by Returning Medical Officers; Opportunities Available Listed

THE purpose of this department is to provide space without cost to Ohio veteran physicians for the publication of inquiries they may wish to make concerning an assistantship or residency, a partnership or space in an office, locations and purchase of a practice, purchase of equipment, etc.

The new feature also offers an opportunity for physicians who desire to dispose of their practice or institutions and agencies needing staff physicians to publicize this information for the benefit of service men.

The feature will appear monthly as long as there seems to be a need for it. The regulations governing it are: (1) The veteran submitting the inquiry must be an Ohio physician, i.e., one who was in practice in Ohio when he entered the service or was a native of Ohio but still in training when he entered in the service. (2) Inquiries should not exceed 35 words. (3) Copy must be submitted by the 20th day of the month preceding date of publication. (4) Unless otherwise specified, each inquiry will be carried in two consecutive issues of *The Journal* but no oftener. (5) *The Journal* reserves the right to reject or edit copy submitted; also, to eliminate the new department when and if conditions warrant. (6) Inquiries should be accompanied by full name, forwarding address and identifying data.

OPPORTUNITIES SOUGHT

LOCUM TENENS DESIRED: Wanted for three months beginning September 15 by Navy medical officer who will begin residency January 1. Graduate of Harvard Medical School in 1944; aged 26; internship Lakeside Hospital, Cleveland. V.I.D. No. 22.

SEEKS INDUSTRIAL ARRANGEMENT: Veteran with extensive industrial background seeks association with individual or group in this type of practice. Willing to invest. Cleveland area preferred but others also considered. V. I. D. No. 23, care of Ohio State Medical Journal.

ASSISTANTSHIP WANTED: Assistantship to general practitioner or radiologist sought by naval officer to be discharged September 1. Age 28. Ohio license. Graduate of Cincinnati University College of Medicine. Rotating internship. Two and one-half years part-time civilian and two years Navy roentgenology. V.I.D. No. 24.

ASSOCIATION DESIRED: Veteran desires position with small medical group or assistantship with pediatrician or general practitioner in town over 20,000. Ultimate desire is to specialize in pediatrics. V.I.D. No. 26.

ASSISTANTSHIP WANTED: Surgeon, aged 32, Army experience and eligible to American Board of Surgery, available in Fall of 1946, desires assistantship to older surgeon, group practice, association with internist, etc. Experience in general surgery, neurosurgery, orthopedic surgery; Ohio license. V.I.D. No. 27.

WANTS ASSOCIATION WITH GROUP OR SPECIALIST: Army veteran, aged 31, married. Ohio State University graduate, Ohio license, eligible to American boards in obstetrics and gynecology, desires position with group clinic or established specialist. Spent 21 months in ETO in general surgery and ob-gyn. V.I.D. No. 29.

SEEKING ASSISTANTSHIP: Army veteran desires assistantship with general practitioner, with possible future partnership. Ohio State University graduate in 1943; rotating internship; aged 30; single. V.I.D. No. 30.

ASSOCIATESHIP, GROUP OR SPECIALIST SOUGHT: Veteran with qualifications for certification by American Board of Internal Medicine, aged 30, graduate of Ohio State University, desires association with group or with board member—preferably with university affiliations. Have had research and teaching experience. V.I.D. No. 31.

LOCUM TENENS SOUGHT: By graduate of Medical College of Virginia, 1939. Also, interested in assistantship in general practice, internal medicine, or pediatrics, beginning in October. Will enter residency University Hospitals, Cleveland, July, 1947. V.I.D. No. 32.

ASSOCIATION SOUGHT: Internist, completing three-year residency in internal medicine, January 1, 1947, interested in association with surgeon, with group or in part-time industrial practice. City of 15,000 or more population desired. V.I.D. No. 33.

LOCUM TENENS: Navy veteran wishes locum tenens or assistantship to general practitioner in Columbus or near vicinity until January 1, 1947. Have residency in medicine starting that date. Graduate, Ohio State University College of Medicine; internship at Los Angeles County General Hospital. V.I.D. No. 34.

OPPORTUNITIES OFFERED

ASSOCIATION WITH SURGEONS: Opening for young man, not interested in surgery, who would like to be associated in practice with two well-established surgeons. Compensation on percentage of gross income to the practice, depending upon training and personal qualifications. Part-time residence could be obtained in a small general hospital at substantial salary while a practice is being built. Industrial town of 15,000 population, Northeastern Ohio. All equipment and supplies furnished. Write H.R.A., care of Ohio State Medical Journal.

OPENING FOR ANESTHETIST: Diplomate of Board of Anesthesiology or fellow of American Society of Anesthesiology wanted as an associate or to practice independently as a full-time anesthetist. Write Fred W. Brosius, M.D., Middletown, Ohio.

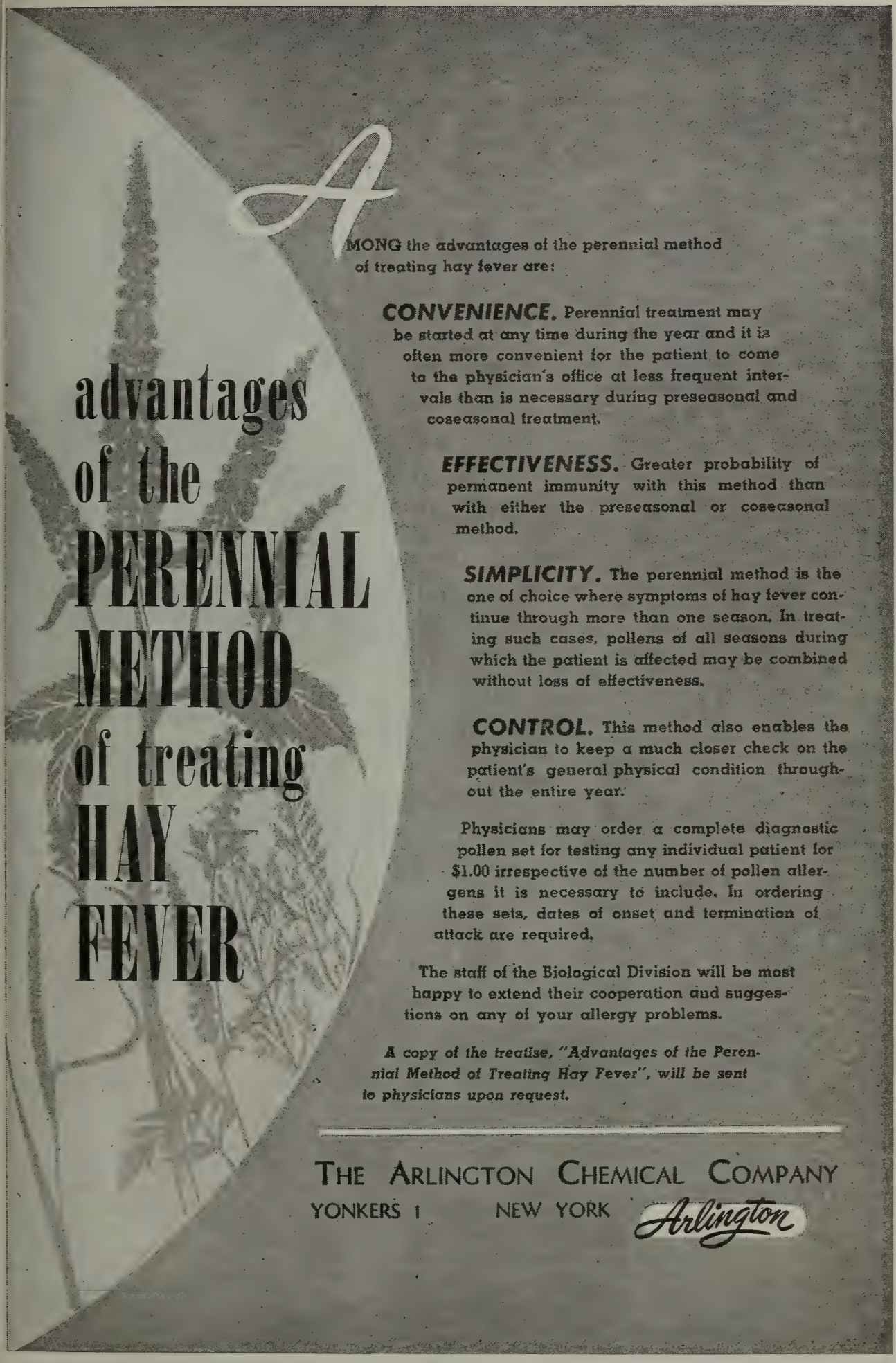
PRACTICE AVAILABLE: General practice in DeGraff available. No property to sell. Forced to retire because of health. Good field for lively young physician. Write O. W. Loffer, M.D., DeGraff.

INTERNS AND HOUSEMEN NEEDED: Good Samaritan Hospital, Dayton, has openings for six interns. Internships approved by American Medical Association. Weekly seminars offered by members of various specialty boards. Also vacancies for four returning veterans as housemen; also entitled to seminars. Stipends for interns $50.00 with full maintenance; stipends for housemen, $150.00 with full maintenance. Contact Intern Committee of hospital.

PRIVATE INDUSTRIAL PRACTICE: Good opportunity for young physician who wishes to engage in private industrial practice in industrial center. Physician now handling work changing locations. If interested, write T.H.L. care of Ohio State Medical Journal.

CLINIC STAFF OPENING: Opening for young man interested in general practice on staff of group clinic. Compensation first few months on salary basis; thereafter on percentage basis. All equipment furnished by clinic. L.A.C. care of Ohio State Medical Journal.

(Continued on page 1078)



advantages of the PERENNIAL METHOD of treating HAY FEVER

AMONG the advantages of the perennial method of treating hay fever are:

CONVENIENCE. Perennial treatment may be started at any time during the year and it is often more convenient for the patient to come to the physician's office at less frequent intervals than is necessary during preseasonal and coseasonal treatment.

EFFECTIVENESS. Greater probability of permanent immunity with this method than with either the preseasonal or coseasonal method.

SIMPLICITY. The perennial method is the one of choice where symptoms of hay fever continue through more than one season. In treating such cases, pollens of all seasons during which the patient is affected may be combined without loss of effectiveness.

CONTROL. This method also enables the physician to keep a much closer check on the patient's general physical condition throughout the entire year.

Physicians may order a complete diagnostic pollen set for testing any individual patient for $1.00 irrespective of the number of pollen allergens it is necessary to include. In ordering these sets, dates of onset and termination of attack are required.

The staff of the Biological Division will be most happy to extend their cooperation and suggestions on any of your allergy problems.

A copy of the treatise, "Advantages of the Perennial Method of Treating Hay Fever", will be sent to physicians upon request.

THE ARLINGTON CHEMICAL COMPANY
YONKERS 1 NEW YORK Arlington

PART-TIME INDUSTRIAL PRACTICE: Good opening for physician interested in part-time industrial practice, physical examinations, and emergencies. Columbus industrial firm. Write C.W.C., care of the Ohio State Medical Journal.

ASSISTANTSHIP TO G.P.: Assistantship to busy general practitioner in large Northwestern Ohio city available; modern office. Percentage basis should average at least $5,000-$6,000 first year; partnership possible, later. Box Z, care of Ohio State Medical Journal.

LOCATION FOR GENERAL PRACTICE: Opening for general practice in town of 3,500 on Ohio River. Office space available. Shortage of active physicians at present. Box S, care of Ohio State Medical Journal.

INDUSTRIAL COMMISSION: Openings available in Medical Section, Ohio Industrial Commission. Consult Dr. Robert André, chief supervisor, Medical Section, State Office Bldg., Columbus.

STATE HOSPITAL STAFF OPENINGS: Staff physicians for various institutions serving the mentally ill, mentally defective and epileptic needed. Physicians who have had some psychiatric training or experience preferred but can offer positions to doctors who may be interested in becoming acquainted with the specialty. A position of special importance now open is: Clinical Directorship, Gallipolis State Institute (fine opportunity for man who has had neuropsychiatric training to become acquainted with those neurological conditions that cause epilepsy in addition to a chance to be a specialist in the field of true epilepsy). Consult Dr. Frank F. Tallman, Ohio Commissioner of Mental Hygiene, State Departments Building, Columbus 15.

PUBLIC HEALTH OFFICERS NEEDED: Several counties in Ohio in need of full-time health commissioners. Those with training and experience, or interested in public health work, may obtain complete details from Dr. Roger Heering, Ohio Director of Health, State Departments Building, Columbus 15.

PRACTICE FOR SALE: Active practice in a community of 3,000, North Central Ohio. Large amount of industrial work in addition to regular practice. Equipment includes new X-ray, diathermy, modern furniture, drugs and supplies. No real estate for sale. Moderate rent. Estimated price $7,500, cash or terms. Will introduce for a short time. Write R.J.S., care of Ohio State Medical Journal.

VETERANS ADMINISTRATION: Openings for physicians as members of rating boards for either full time or part time duty. Basic salary $4300.00 per annum, with additional compensation for overtime. Contact nearest V.A. office for particulars.

FULL-TIME RESIDENT PHYSICIAN NEEDED: At Homeplace, Perry County, Kentucky, operated by E. O. Robinson Mountain Fund as educational center for mountain people. Graduate nurse; clinic building being planned; affiliation with medical center in Cincinnati for consultation and specialized services; salary $5,000 per year, with home and transportation furnished. Write Dr. Howard P. Fischbach, 1122 Carew Tower, Cincinnati 2, Ohio.

PRACTICE AND HOME FOR SALE: Active practice established 10 years in town of 2000 with local post office serving 8000. Brick and stone home with modern interior. Has suite of rooms for office. All modern office equipment with stock of drugs and X-ray, diathermy, ultraviolet. Seeing more than 20 patients per day. Physician urgently needed. Forced by service-connected disability to retire from general practice. All is offered to a veteran for price of real estate alone. Liberal terms; can pay for all in three years from earnings. M. R. Wedemeyer, M.D., Oak Hill, Ohio.

HOSPITAL OPENING: Summit County Receiving Hospital, recently opened by welfare department, in need of assistant physician psychiatrist to do work of physician on military leave. Man under 35 years of age with residency in psychiatry preferred. Pay, $275.00 per month in addition to maintenance for self and family. Hospital also needs graduate nurses to complete staff, pay scale $163.00 for general floor duty to $196.00 for supervisory duty and Instructor, R. N. and a Director of Nurses, R. N. with baccalaureate degree. Write Summit County Receiving Hospital, Cuyahoga Falls, Ohio.

INDUSTRIAL POSITION: Wanted, physician between ages 30-40 interested in a career in industrial medicine. Some experience in surgery required. To have charge of medical department. Salary to start, $7,500.00-$8,000.00. Needed immediately. Opportunity for advancement. Large manufacturing firm in Northern Ohio. State age, education and experience. Box 200, care of Ohio State Medical Journal.

MEDICAL DIRECTOR SOUGHT: Full-time medical director for new Ohio division of large national industry located in Northern Ohio. Well-equipped medical department. Want man with some industrial experience; ability and personality to promote public relations in this type of work. Box 300, care of Ohio State Medical Journal.

Veterans Administration Announces Two Recent Medical Appointments

Dr. Peter A. Volpe, Worthington, former Columbus physician who recently was separated from the Army Medical Corps, has been appointed Chief of Medical Rehabilitation for the Veterans Administration in Ohio, Michigan, and Kentucky.

Dr. Volpe received his B.S. and M.D. degrees from Ohio State University. He served his internship at White Cross Hospital and practiced in Columbus from August 1, 1932, until September 4, 1942, when he was called to active duty with the Sixth Armored Division. He was seriously wounded in action on February 5, 1945, after serving a year overseas and participating in the Normandy, Northern France, Ardennes, and Rhineland campaigns. He attained the rank of Major.

The appointment of Dr. Harrison S. Collisi to the managership of Crile Veterans Administration Hospital, Cleveland, has been announced by Branch Office No. 6 of the Veterans Administration. Dr. Collisi was formerly chief of outpatient division for Branch 6.

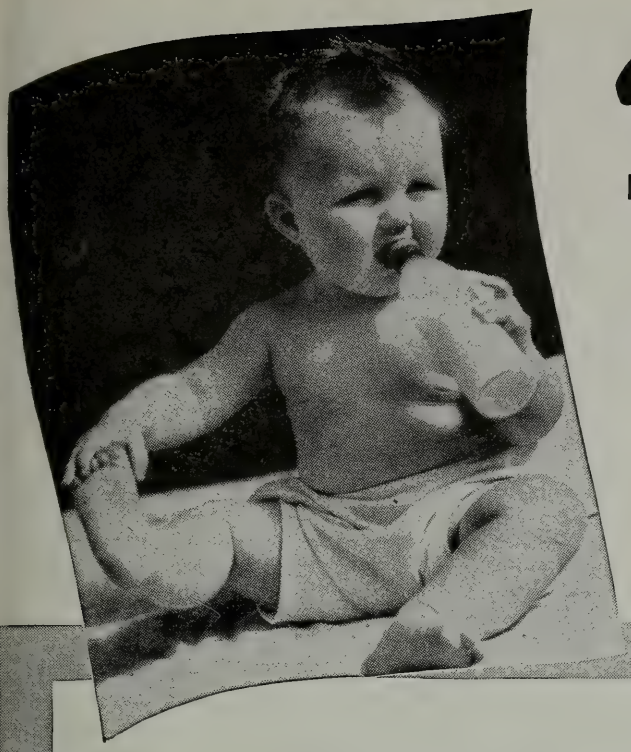
Dr. Collisi received his medical training at the University of Michigan, graduating in 1912. He began his practice in Grand Rapids, Michigan, where he specialized in obstetrics and gynecology, later becoming Chief of the Medical Staff of Butterworth Hospital.

During his practice in Michigan, Dr. Collisi served for some time as chairman of the public relations committee of the Michigan State Medical Society.

In May, 1942, he entered military service as a major and was appointed chief of surgical service at Billings General Hospital in Indianapolis, Indiana. In July, 1943, he was promoted to Lt. Colonel and appointed post surgeon at Ft. Benjamin Harrison, Indiana. From May, 1944, to October, 1944, he received pre-activation training at Camp Ellis, Illinois. During that period, he activated and was named commanding officer of the 197th General Hospital.

Dr. Collisi's overseas service began in November, 1944. He returned to the United States in December, 1945, to be separated at Camp Atterbury, Indiana, and as a colonel received his discharge March 16, 1946.

Charles S. Nelson, executive secretary of the Ohio State Medical Association, participated in a panel discussion on "Ohio's Health Services" at a general session of the Ohio Congress of Parents and Teachers, September 25, at Memorial Hall, Columbus. Copies of the booklet "The 25 To Keep Alive" explaining the Association's 25-point health program for Ohio, were distributed at the meeting.



4 REASONS WHY

more and more physicians are prescribing BAKER'S MODIFIED MILK for the bottle-fed infant, *beginning right in the hospital*

1. Baker's Modified Milk is a highly nutritious food that is well tolerated by both premature and full-term infants . . .

2. . . . may be used either complemental to or entirely in place of human milk . . .



POWDER

LIQUID

3. . . . may be prescribed at any period—at birth or when mother's milk fails . . .

4. . . . no need for changing the formula as the infant grows older—just increase the quantity of feeding.

Start with either and change from one to the other, to meet individual requirements.

Of course, the paramount reason for the fast-increasing use of Baker's Modified Milk is the good results doctors are obtaining with this food in a majority of their infant-feeding cases.

In addition to the factors listed above, Baker's has many other preference-winning attributes, such as the simple directions required: just dilute with water, previously boiled . . . and its efficacy in the correcting of regurgitation, constipation, and loose or too-frequent stools.

Mothers like to feed Baker's Modified Milk because it is convenient and economical to use.

Baker's Modified Milk is advertised only to the Medical profession. Just leave instructions at the hospital. The obstetrical supervisor will be glad to put your next bottle-fed infant on Baker's Modified Milk.

• Baker's Modified Milk is made from tuberculin-tested cows' milk in which most of the fat has been replaced by animal and vegetable oils with the addition of lactose, dextrose, gelatin, iron ammonium citrate, vitamins A, B1 and D. Not less than 400 units of vitamin D per quart.

Complete information gladly sent on request.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

BAKER'S MODIFIED MILK

THE BAKER LABORATORIES, INC., CLEVELAND, OHIO

BRANCH OFFICES: SAN FRANCISCO, LOS ANGELES and DENVER

Majority of Freshmen Medical Students Are Veterans But Number Smallest in 17 Years, Council's Report Shows

SIXTY per cent of the 4,666 students who have been selected as freshmen to enter medical schools and schools of basic sciences in the United States in 1946 are war veterans.

The freshmen students selected up to June, 1946 included male veterans 2,816 (60 per cent), physically disqualified men 501 (11 per cent), occupationally deferred men 312 (7 per cent), men under 18 years 41 (1 per cent), other men 429 (9 per cent), and women 567 (12 per cent).

These figures were contained in the 46th annual report in medical education in the United States and Canada by the Council on Medical Education and Hospitals of the American Medical Association. The report was published in the August 17 issue of *The Journal of the American Medical Association.*

Victor Johnson, M.D., secretary of the council, who prepared the report with the assistance of F. H. Arestad, M.D., and Anne Tipner, said that the large number of war veterans in this year's class "must be attributed to the unexpectedly short time which elapsed between V-E day and V-J day and the consequently rapid demobilization of the Army and Navy".

Continuing, his report said:

SMALLEST FRESHMAN CLASS

"The medical schools in this country, having selected 4,666 students for the 1946 entering class, state that 1,079 remain to be selected to complete the projected freshman class. This indicates that the freshman class will number about 5,745. If this number is not exceeded before classes open, this year's freshman enrollment will be the smallest in 17 years.

"Whether the 1946 class will be filled remains to be seen. Almost all schools hope to fill their 1946 freshman class and, in general, they judge the qualifications of those admitted to be about the same as those of freshman students before the war."

THE ACCELERATED CURRICULUM

The council report said that by June 1, 1946 all but five of the four-year medical schools had completed the three-year cycle of four graduating classes under the accelerated program which was in effect during the war years. Both the Army specialized training program and the Navy V-12 program have been discontinued.

"It is regrettable that the educational experiment of acceleration could not be carried out under more favorable conditions", the report said, adding: "There is a tendency to ascribe all the deficiencies of wartime medical education to the accelerated program. Other important deleterious influences were operating entirely independently of acceleration in the medical schools. Among these were shortages of teaching staff, increased enrollments, inadequate premedical preparation, and a state of uncertainty in the minds of students as to their future. Could the experiment have been conducted in the absence of these variables, perhaps the reaction against acceleration would now be less widespread."

The council said that by 1947, at which time all scheduled extra graduations will have been completed, the wartime medical school program will have produced an estimated extra 7,214 physicians.

NEW MEDICAL SCHOOLS

The council's report contained the following additional information:

"There are two institutions which are well on the way toward establishment of entirely new medical schools. These are the University of Washington, which is organizing a medical school in Seattle, and the University of California, which will establish a school in the Los Angeles area as a part of the Los Angeles branch of the university. In Canada, a new medical school has been established by the University of Ottawa.

"The Hahnemann Medical College in Philadelphia is on probation, as are also the basic science schools of North Dakota and South Dakota.

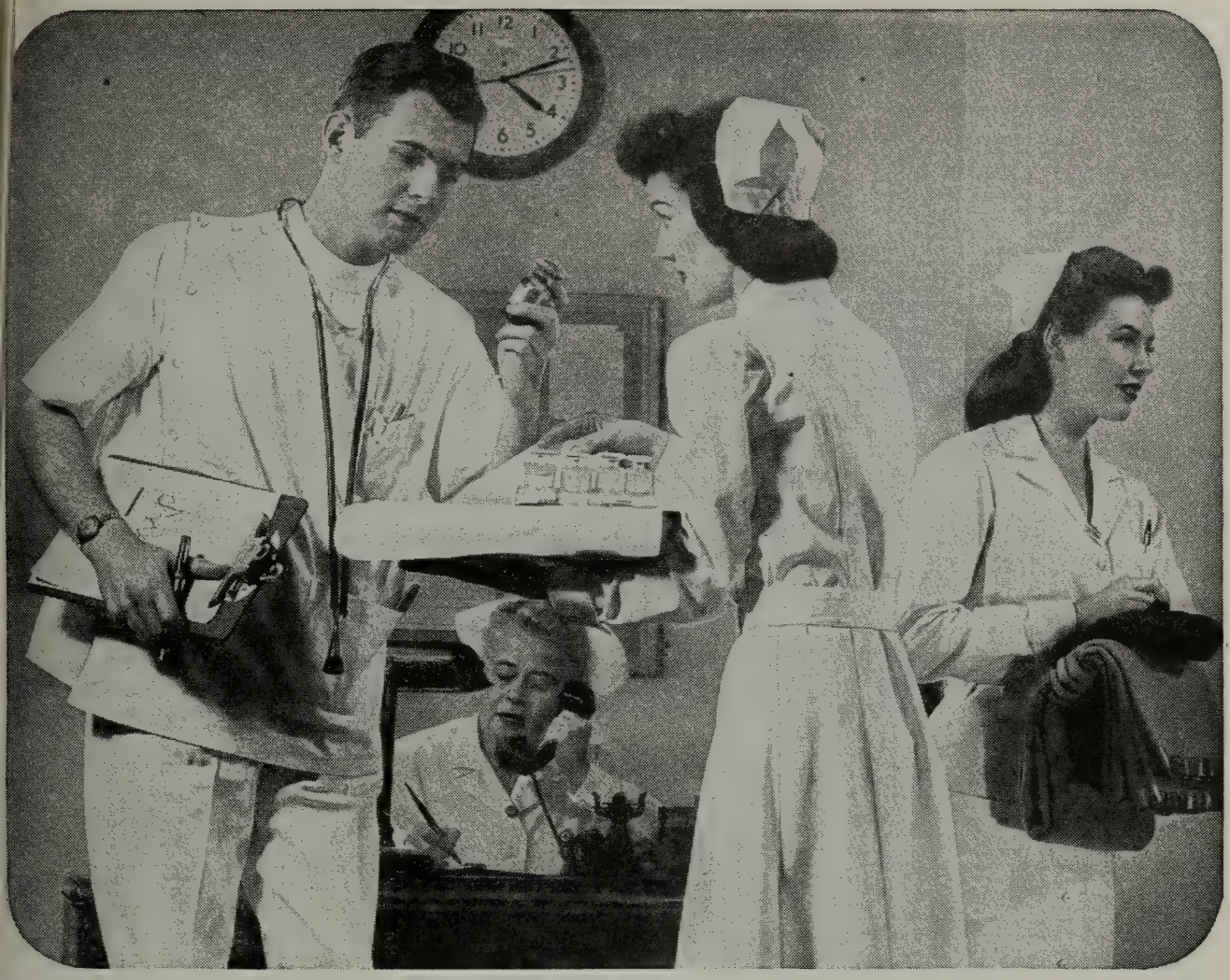
"In the 69 medical and eight basic science schools in the United States there were 23,216 students enrolled for the 1945-46 session. This number, exclusive of students in the intern year, is only 812, or about three per cent, less than the enrollment of 24,028 in the preceding 1944-45 session. Total enrollments have not changed appreciably in the past three academic sessions.

"In the United States, 1945-46 enrollments of over 500 students occurred at seven medical schools: Illinois, 647; Jefferson, 605; Northwestern, 565; Michigan, 543; New York University, 517; Pennsylvania, 516; and Hahnemann, 509. The latter school, with one of the highest enrollments in the country, is on probation. There were seven schools with enrollments under 200.

"In Canada, the highest enrollment occurred at Toronto with 860 students.

NEW GRADUATES HIGHEST

"From July 1, 1945 to May 31, 1946, there were 5,826 medical school graduates in the United States and 513 in Canada. The 5,826 graduates for the 1945-46 year is the highest figure since the Council on Medical Education and Hospitals was established in 1904. This number, it is true, includes the figures for two graduating classes in four schools. But even if this is taken into

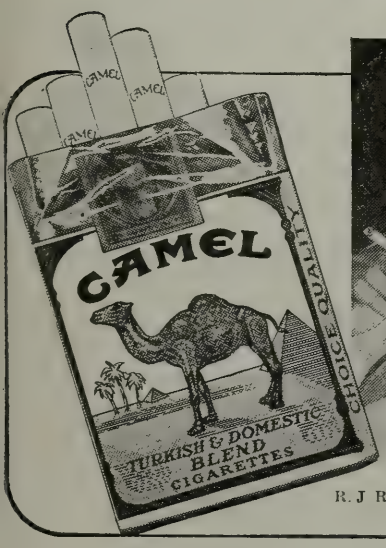


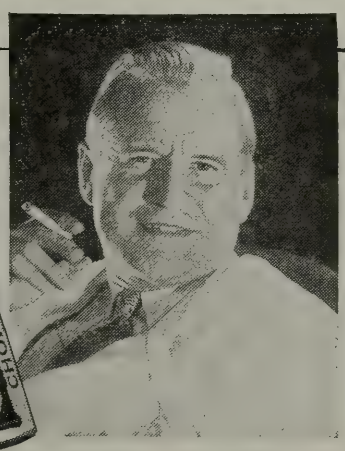
Young Man in White

● You may call him an "interne," but in name and in fact he's every inch a doctor.

He has his textbook education . . . his doctor's degree. But, in return for the privilege of working side by side with the masters of his profession, he will spend a year—more likely two—as an active member of a hospital staff.

His hours are long and arduous . . . his duties exacting. But when he finally hangs out his coveted shingle in private practice he will be *a doctor with experience!*





According to a recent independent nationwide survey:

More Doctors Smoke Camels

than any other cigarette

R. J. Reynolds Tobacco Company, Winston-Salem, N. C.

account the figure will still remain the highest in over 40 years.

"The increased number of graduates in an academic year has nothing to do with the accelerated program. It is a reflection of the wartime policy of admitting more students to our medical schools.

INCREASE IN RESIDENCIES

"Facilities for residency training in hospitals approved by the Council on Medical Education and Hospitals have increased by 70 per cent since 1941. At the present time the number of residencies in specialties totals 8,930 as compared with 5,256 at the beginning of the war."

COMING MEETINGS

Ohio State Medical Association, Cleveland, May 6-8, 1947.

American Medical Association, Atlantic City, June 9-13, 1947.

House of Delegates, American Medical Association, Semi-annual meeting, Chicago, Dec. 9-11.

Annual Conference of State Secretaries and Editors, Chicago, Dec. 7-8.

American Association on Mental Deficiency, Montreal, Canada, Oct. 2-4.

American Academy of Ophthalmology and Otolaryngology, Chicago, Oct. 13-18.

American Association of Railway Surgeons, Chicago, Oct. 29-31.

American Clinical and Climatological Association, Hershey, Pa., Oct. 21-23.

American College of Physicians, Chicago, April 28-May 2, 1947.

American College of Surgeons, Cleveland, Dec. 16-20.

American Dietetic Association, Cincinnati, Oct. 14-18.

American Public Health Association, Cleveland, Nov. 12-14.

International College of Surgeons, U. S. Chapter, Detroit, Oct. 21-23.

Association of Military Surgeons of the United States, Detroit, Oct. 9-11.

Interstate Postgraduate Medical Association, Cleveland, Oct. 15-18.

National Society for the Prevention of Blindness, New York, Nov. 25-27.

National Conference on Rural Health, Chicago, Feb. 7-8, 1947.

National Conference on Medical Service, Chicago, Feb. 9, 1947.

National Congress on Medical Education, Chicago, Feb. 10-11, 1947.

Association of American Medical Colleges, New Orleans, Oct. 28-30.

Ohio and American Anesthesiologists To Meet In Cincinnati Nov. 1 and 2

A joint meeting of the Ohio and the American Societies of Anesthesiologists will be held Friday and Saturday, November 1 and 2, at the Hotel Gibson in Cincinnati.

At 9 a.m. November 1 the following subjects will be discussed by the speakers indicated:

1. Panel on Curare.
   a. Pharmacology, Dennis E. Jackson, Prof. of Pharmacology, Cincinnati.
   b. Specific Indications in Anesthesia, Norris E. Lenehan, M.D.
   c. Curare Substitutes, A. J. Kuehn, M.D.
   d. Dangers, Complications, and Precautions, Wm. A. Friend, M.D.

   Discussion
2. Saddle Block Spinal Anesthesia, L. E. Larrick, M.D.
3. Panel on Ether Anesthesia
   a. Methods of Induction, George F. Collins, M.D.
   b. Open, Semi-closed, Closed, J. R. Jarvis, M.D.
   c. Dangers, Fred P. Haugen, M.D.
   d. Special Indications, Stanley Gardner, M.D.
   e. Special Contraindications, A. J. Kuehn, M.D.

   Discussion
4. (Subject Pending), T. H. Sheldon, M.D.

Following is the agenda for the afternoon of Friday, November 1:

1. Economics in Anesthesia, Fred P. Haugen, M.D.
2. Panel on Thoracic Surgery
   a. Physiology, Robert L. Patterson, M.D.
   b. Surgical Considerations, Elmer Maurer, M.D.
   c. Intratracheal, Paul M. Yordy, M.D.
   d. Agents, Lloyd H. Mousel, M.D.

   Discussion
3. Recent Advances in Oxygen Research, Wm. Machle, M.D.
4. Business Meeting

At 7 p.m. the same day, a dinner meeting is scheduled, the program of which is still tentative at this writing.

On Saturday, November 2, the meeting will conclude with a morning session, beginning at 9 a.m.

1. Panel on Sympathetic Block
   a. Uses and Abuses, E. A. Rovenstine, M.D.
   b. Indications and Contraindications, Robert L. Patterson, M.D.
   c. Physiology, Carl C. Dameron, M.D.
   d. Technique, Lloyd H. Mousel, M.D.

   Discussion
2. The Treatment of the Unconscious (Anesthetized) Patient, Earl Rosenblum, M.D.

   Discussion
3. Anesthesia in Emergency Surgery, Wm. A. Friend, M.D.



WELL TOLERATED by the NEWBORN

Clinical experience establishes that CARTOSE* is especially well tolerated by newborn infants.

CARTOSE supplies carefully balanced amounts of non-fermentable dextrins, with maltose and dextrose. These offer the advantages of: spaced absorption because of the time required for hydrolysis of the higher sugars ; less likelihood of distress due to the presence of excessive amounts of fermentable sugars in the intestinal tract at one time.

CARTOSE is liquid; formula preparation is simple, rapid, and accurate. It is compatible with any formula base: fluid, evaporated, or dried milk.

*The word CARTOSE is a registered trademark of H. W. Kinney and Sons, Inc.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

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Mixed Carbohydrates

H. W. KINNEY & SONS, INC. (Kinney trademark) **COLUMBUS, INDIANA**

In Memoriam

Ernest V. Ackerman, M.D., Fredericktown; Ohio Medical University, Columbus, 1902; aged 71; died Aug. 12; member of the Ohio State Medical Association and Fellow of the American Medical Association. Dr. Ackerman had served as president of the Knox County Medical Society in 1934, 1935, and 1945. He was vice-president in 1932, 1933, 1943, and 1944. A lifelong resident of Fredericktown, he had practiced medicine there for 42 years. He served on the local board of education for 25 years; was a member of the Knox County Board of Health, the Memorial Building Commission, and the First Presbyterian Church. He was a past commander of Knights Templar and a 50-year member of the Masonic Lodge. Surviving are his widow, three sons, a daughter, two brothers, and two sisters.

William Wilson Bailey, M.D., Cincinnati; Miami Medical College, Cincinnati, 1890; aged 83; died Aug. 27. Dr. Bailey had retired three years ago after practicing medicine for more than 50 years in the Cincinnati area. He was a member of the Masonic Lodge. Surviving are his widow, two sons, and two daughters, one of whom is Dr. Rea Bailey, Cincinnati.

Ray Harmes Bechtell, M.D., Dayton; Eclectic Medical College, Cincinnati, 1917; aged 54; died Aug. 22; member of the Ohio State Medical Association and Fellow of the American Medical Association. Dr. Bechtell had practiced medicine in Dayton for 28 years and was formerly associated with his father, Dr. Elmer E. Bechtell, who died in 1943. A veteran of World War I, Dr. Bechtell was a member of the Masonic Lodge and the United Brethren Church. His mother survives.

Byron Bing, M.D., Pomeroy; Starling Medical College, Columbus, 1902; aged 70; died Aug. 10; member of the Ohio State Medical Association and the American Medical Association. Dr. Bing was vice-president of the Meigs County Medical Society in 1926 and 1927; secretary-treasurer from 1928 through 1932; legislative committee chairman from 1925 through 1932 and from 1936 through 1939; and delegate to the Ohio State Medical Association from 1932 through 1940. He was also a member of the American Legion, the Isaac Walton League, and the Presbyterian Church. Surviving are his widow, two daughters, one son, three sisters, and a brother.

Louis Samuel Deitchman, M.D., Youngstown; University of Pennsylvania School of Medicine, Philadelphia, 1921; aged 53; died Sept. 4; member of the Ohio State Medical Association; Fellow of the American Medical Association; Diplomate of the American Board of Otolaryngology; and member of the American Academy of Ophthalmology and Otolaryngology. Dr. Deitchman was treasurer of the Mahoning County Medical Society from 1934 to 1936; was president of the staff of the Mahoning County Tuberculosis Sanitarium and a member of the staff of the Youngstown Hospital Association. He was discharged from the armed forces in April after overseas service as a lieutenant colonel in the Army Medical Corps. Dr. Deitchman had written a number of articles on medical history and was an accomplished violinist. He was a member of the Masonic Lodge. Surviving are his widow, three sisters, and three brothers, including Dr. Morris Deitchman of Youngstown.

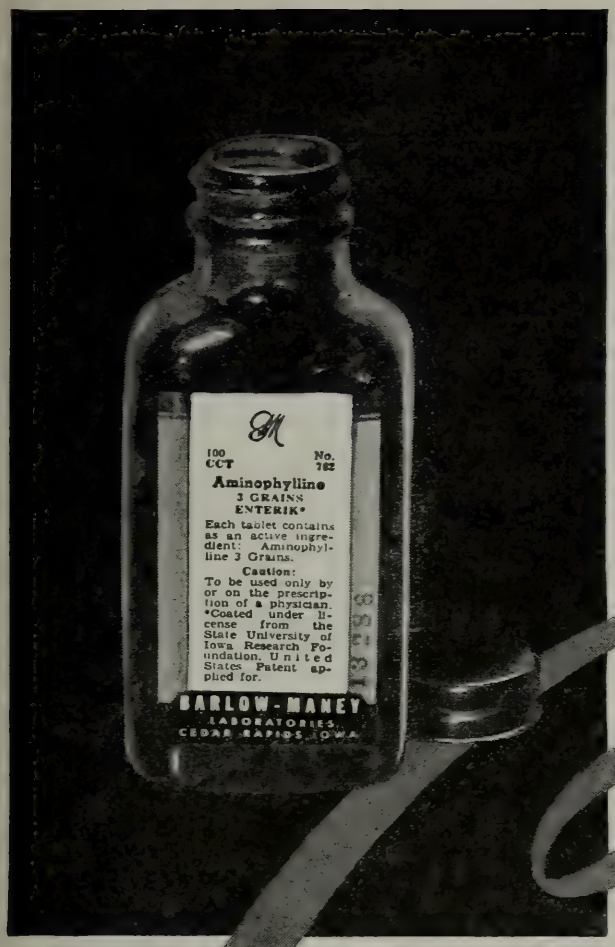
Joseph Paul Fakehany, M.D., Toledo; Loyola University School of Medicine, Chicago, 1939; aged 34; died Aug. 17; member of the Ohio State Medical Association and the American Medical Association.

James Gladdin Freshour, M.D., Covington; Miami Medical College, Cincinnati, 1901; aged 70; died Aug. 18; former member of the Ohio State Medical Association and the American Medical Association. Dr. Freshour served as an infantry captain in World War I, and practiced medicine in Miami County from the end of the war until his retirement in 1936. He was a member of the Masonic Lodge. His widow and a stepdaughter survive.

Louis Goldberg Heyn, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1902; aged 68; died Aug. 21; member of the Ohio State Medical Association, Fellow of the American Medical Association, and Diplomate of the American Board of Internal Medicine. Dr. Heyn was president of the staff of the Jewish Hospital in Cincinnati, and had been an associate professor of medicine at the University of Cincinnati College of Medicine. He was the author of a number of medical articles, and had traveled extensively in Europe. Surviving are a son, daughter, and two sisters.

Edward John Keeney, M.D., Cuyahoga Falls; St. Louis University School of Medicine, 1933; aged 38; died June 14; member of the Ohio State Medical Association and Fellow of the American Medical Association. Dr. Keeney, a native of Ironton, Ohio, had established practice in Summit County in 1934. He served as a medical officer in the Army Medical Corps from August, 1942, until November, 1943.

Harrie Breckinbridge Martin, M.D., Springfield; University of Pennsylvania School of Medicine, Philadelphia, 1903; aged 68; died Sept. 1;



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former member of the Ohio State Medical Association and Fellow of the American Medical Association. Dr. Martin had retired about a year ago after having practiced medicine in Springfield since 1907. He was the founder of the Children's Ward in the old City Hospital, Springfield; a member of the Presbyterian Church, Rotary Club, Masonic Lodge, and the A.O.A. scholastic honorary medical society. He is survived by his widow, two sons, one of whom is Dr. Morris B. Martin of Springfield, a daughter, and two sisters.

Gordon Frank McKim, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1903; aged 67; died Sept. 2; member of the Ohio State Medical Association, Fellow of the American Medical Association, Diplomate of the American Board of Urology, member of the Association of Genito-Urinary Surgeons, American Urological Association, and Fellow of the American College of Surgeons. Dr. McKim was president of the Academy of Medicine of Cincinnati in 1921 and vice-president in 1918. He was professor of urology at the University of Cincinnati College of Medicine; director of urologic service at Cincinnati General Hospital; president of the staff of Christ Hospital from 1936 to 1938; past-president of the North Central Branch of the American Urologic Association, and charter member and founder of the American Board of Urology. He was a member of the Masonic Lodge, Beta Theta Phi and Nu Sigma Nu fraternities. Dr. McKim was the recipient of the honorary degree of doctor of laws from both Hanover College and Miami University. He served as a captain in the Army Medical Corps in World War I. Surviving are his widow, a son, and a brother.

Andrew Joseph McNamara, M.D., Cleveland; University of Wooster Medical Department, Cleveland, 1896; aged 74; died Aug. 23. Dr. McNamara had practiced medicine in Cleveland for 35 years. He retired in 1934. Surviving are his widow and a daughter.

West Montgomery, M.D., Painesville; Starling Medical College, Columbus, 1885; aged 88; died Sept. 8; former member of the Ohio State Medical Association and the American Medical Association. Dr. Montgomery was president of the Lake County Medical Society in 1926, vice-president in 1921, and secretary-treasurer in 1923, 1924, and 1925. He began his career as a school teacher; became a justice of the peace at age 21; and later served as mayor of Ada, Ohio. He had practiced medicine for 57 years in Mercer, Hardin, and Lake Counties. Dr. Montgomery was a life-long member of the Presbyterian Church and a 50-year member of the Knights of Pythias Lodge. Surviving are his widow, six daughters, and two sons.

John M. Patterson, M.D., Winterhaven, Florida; Medical College of Ohio, Cincinnati, 1902; aged 69; died Aug. 22. A native of Logan County, Dr. Patterson had practiced medicine in Lima for 30 years until his retirement in 1934. He was a member of the Presbyterian Church. Surviving are a son and a brother.

James M. Pedicord, Sr., M.D., Zanesville; Ohio Medical University, Columbus, 1893; aged 79; died Aug. 24; former member of the Ohio State Medical Association and the American Medical Association. Dr. Pedicord had practiced medicine in Zanesville for 41 years and was a former Muskingum County coroner. He was a member of the Presbyterian Church. Surviving are his widow, a son, a daughter, two brothers, and two sisters.

Harold Vincent Phelan, M.D., Cleveland; Georgetown University School of Medicine, Washington, D. C., 1921; aged 51; died Aug. 31; member of the Ohio State Medical Association; Fellow of the American Medical Association; and Diplomate of the American Board of Ophthalmology. Dr. Phelan had practiced in Cleveland for 25 years and was head of the eye department of St. Alexis' Hospital in that city. His widow, a son, a daughter, and a brother survive.

David O. Roberts, M.D., Hanover; Eclectic Medical College, Cincinnati, 1880; aged 89; died Sept. 10. Dr. Roberts practiced medicine in Licking, Muskingum, and Knox Counties for 52 years. He was a 50-year member and past master of the Hanover Masonic Lodge, and an elder of the Presbyterian Church for 50 years. Three daughters, a son, and a brother survive.

Alex Morton Rosenblum, M.D., Youngstown; University of Pennsylvania School of Medicine, Philadelphia, 1912; aged 56; died Sept. 6; member of the Ohio State Medical Association and the American Medical Association. Dr. Rosenblum had practiced medicine in Youngstown for 33 years, and was chief of medicine at St. Elizabeth Hospital in that city. He was a veteran of World War I. Surviving are his widow, two children, three brothers, and a sister.

Bertha Satterlee, M.D., Bellevue; Cleveland College of Physicians and Surgeons, 1894; aged 78; died Sept. 2. Dr. Satterlee had retired from practice about 12 years ago. A daughter survives.

Adolph Benedict Schneider, M.D., Cleveland; Cleveland Medical College, 1894; aged 80; died Sept. 4; member of the Ohio State Medical Association and Fellow of the American Medical Association. Dr. Schneider was chief of the department of medicine at the Huron Road Hospital. His widow, a son, and a daughter survive.

Otto John Seibert, M.D., Cincinnati; Long Island College of Medicine, Brooklyn, 1909; aged



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60; died Aug. 22; member of the Ohio State Medical Association, the American Medical Association; and Fellow of the American College of Surgeons. Dr. Seibert was a delegate from Hamilton County to the Ohio State Medical Association from 1930 through 1940, and was one of the founders and editors of the *Cincinnati Journal of Medicine.* Dr. Seibert had practiced in Cincinnati since 1912, and was a former president of the staff at Deaconess Hospital in that city. He was an accomplished pianist and painter and was active in Cincinnati civic clubs. He is survived by his widow, a son, two sisters, and four brothers.

R. G. Paterson Retires; Louis Named Secretary of Health Association

John A. Louis, Columbus, has been appointed Executive Secretary of the Ohio Tuberculosis and Health Association, succeeding Robert G. Paterson, Ph.D., who is retiring after 35 years in that position. A native of Hamilton, Mr. Louis has been assistant secretary since Sept. 1, 1941. He had previously been director of public relations for the Fort Hamilton Hospital, Hamilton; member of the staff of the National Tuberculosis Association; and director of the Ohio Social Planning Project in 1940. He was in the Army for over two years, serving in England, France, and Germany with the Sixth Armored Division. Since Oct. 1, 1945, Mr. Louis has been executive secretary of the Joint Committee on Tuberculosis Control in Ohio.

Long active in the tuberculosis movement in Ohio and throughout the country, Dr. Paterson became executive secretary of the Ohio Society for the Prevention of Tuberculosis, May 1, 1911. He helped to organize the division of tuberculosis in the Ohio Department of Health in 1913. Since 1933 he has been a professor in the School of Administration, Ohio State University.

Dr. Paterson has served as secretary for the Committee on Archives of the National Tuberculosis Association since 1934 and has written and published numerous articles in this field. He has done much writing on medical history, including several contributions to the Historian's Notebook of *The Ohio State Medical Journal.*

Retiring with the title of executive secretary emeritus and director of research, Dr. Paterson will be engaged in three projects: the writing of a text in Community Health Organization for the School of Social Administration, Ohio State University; a history of the tuberculosis movement in Ohio; and a history of the public health movement in Ohio.

Marion—Dr. Robert T. Gray, Prospect, described the development of antibiotic drugs at a meeting of the Lions Club.

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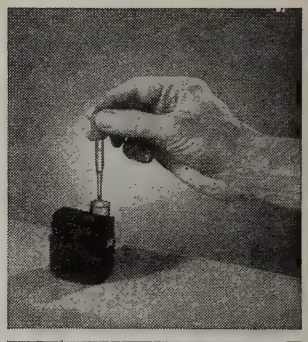
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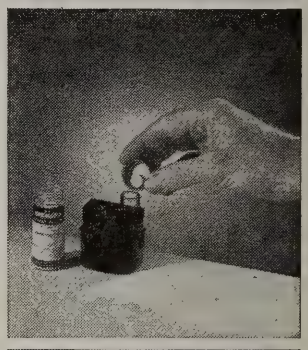
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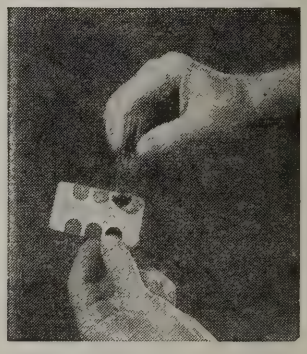
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Do You Know - - -

An exhibit featuring the 25-point health program for Ohio as adopted by the House of Delegates of the Ohio State Medical Association in May, will be presented at the annual meeting of the American Public Health Association in Cleveland November 12-14 in the Public Auditorium. Copies of the booklet "The 25 to Keep Alive" will be distributed from the booth, which is located in the scientific exhibit area, number 331.

* * *

Research on animals for the development of life-saving medical knowledge has been endorsed by the Chamber of Commerce of the United States in a statement of policy released recently by Howard Strong, Secretary of the Health Advisory Council of the Chamber of Commerce, following a referendum vote of member organizations.

* * *

Dr. Leonard G. Rowntree became the seventeenth civilian to be recognized by Presidential order for wartime services, when the medal of merit was bestowed on him in recognition of his services as chief of the Selective Service medical division during World War II. He is now serving as chairman of the American Legion Medical Advisory Board.

Hart F. Page, assistant director of public relations of the Ohio State Medical Association, is chairman of the Committee on Public Health of the Columbus Junior Chamber of Commerce and a member of the Committee on Public Health of the Ohio Junior Chamber of Commerce.

* * *

The W. K. Kellogg Foundation, Grand Rapids, Mich., has made a grant of $57,950 to Western Reserve University, for the purpose of expanding the training program for public health nurses in service and conducting special research projects in nursing education and in pediatric nursing.

* * *

A member of the teaching staff at Western Reserve University for 47 years, Dr. William H. Weir has retired from the post of clinical professor of gynecology, under the 70-year rule. He will continue his private practice in Cleveland.

* * *

Dr. Louis J. Karnosh, Cleveland, has been named head of a newly created department of neuropsychiatry at the Cleveland Clinic. Also, Dr. Karnosh has been promoted from associate clinical professor of neurology at Western Reserve University School of Medicine to a full

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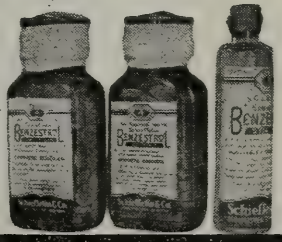
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professorship. He will remain as head of the neuropsychiatric department at the Cleveland City Hospital. Full-time associates of Dr. Karnosh in the new department at the Cleveland Clinic will be Dr. Guy H. Williams, Jr., and Dr. Edward Zucker.

* * *

Charles E. Nyberg, since 1938 an associate in the Bureau of Medical Economics of the American Medical Association, has resigned to become assistant to Mac Cahal, executive secretary of the American College of Radiology, Chicago.

* * *

The Nutrition Foundation has awarded $10,000 to the University of Cincinnati for a period of two years, at the rate of $5,000 per annum, for clinical and experimental research on diabetes, especially in the young.

* * *

Dr. Joseph T. Wearn, Cleveland, Dean of Western Reserve University School of Medicine, is secretary of the Association of American Physicians.

* * *

The American Society for the Hard of Hearing has changed its name to the American Hearing Society. Headquarters are at 1537 Thirty-Fifth St., N. W., Washington 7, D.C.

* * *

Dr. Charles L. Brown, professor of medicine, Temple University School of Medicine, Philadelphia, has been appointed dean of Hahnemann Medical College and Hospital, Philadelphia, effective Sept. 1. Dr. Brown graduated at the University of Oklahoma School of Medicine, Oklahoma City, in 1921. He is a past president of the Philadelphia County Medical Society.

* * *

The Research Council on Problems of Alcohol claims that of the 50,000,000 persons in the United States who use alcoholic beverages, approximately six per cent become excessive drinkers and of the excessive drinkers, about 25 per cent become chronic alcoholics.

* * *

Dr. Louis Mark, Columbus, was elected Second Vice-President of the American College of Chest Physicians, at the annual meeting of the College held in San Francisco last June.

* * *

Dr. Edgar P. McNamee, Cleveland, President of the Ohio State Medical Association, delivered the address of welcome at the annual meeting of the American Roentgen Ray Society, held in Cincinnati, Sept. 17-20.

* * *

In 1945 there were 47,406 eye injury cases reported in claims filed with the State Industrial Commission, 19.1 per cent of all injury claims filed during the year. Classified by nature of injury to eyes, there were 3,431 cases due to burns and scalds; 928, contusions; 7,029, foreign

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bodies; 8,154, cuts and lacerations; 25,632, puncture wounds; 75, occupational diseases; and 2,157, unclassified.

* * *

Eleven hundred and twenty-three of the approximately 5,000 persons at whose birth Dr. C. D. Leggett, Chillicothe, was the attending physician, marched in a parade in his honor, Aug. 23, during the Ross County Fair. A graduate of Starling Medical College, Columbus, in 1902, Dr. Leggett has practiced in Chillicothe for over 40 years.

* * *

The $34,000 prize contest for physicians' art work on the subject of "Courage and Devotion Beyond the Call of Duty" will be judged at the Atlantic City Centennial Session of the A.M.A. at Atlantic City, June 9-13, 1947. Art works on other subjects may also be submitted for the regular cups and medals. For full information, write Dr. F. H. Redewill, Secretary, American Physicians Art Association, Flood Building, San Francisco, Calif., or to the sponsor, Mead Johnson & Company, Evansville 21, Ind.

* * *

The American Association for the Study of Goiter again offers the Van Meter Prize Award of $300 and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. Essays must be submitted prior to January 1, 1947. Further details may be obtained by writing Dr. T. C. Davidson, corresponding secretary, 207 Doctors Bldg., Atlanta 3.

* * *

Dr. Jonathan Forman, Editor of *The Ohio State Medical Journal*, was one of the speakers at the Lutheran Rural Church Life Institute held at Wittenberg College, Springfield, Sept. 2-6.

Medical Society Exhibit Attracts Crowd at Canfield Fair

An exhibit sponsored by the Mahoning County Medical Society at the centennial Canfield Fair, August 25 to September 2, was visited by a large number of fair goers, according to Dr. William M. Skipp, Youngstown.

Members of the society checked all incoming visitors at one of the entrances of the large tent housing the display, and found that the total was 60,000.

Based on the theme of one hundred years of medicine, the exhibit included saddlebags, instruments, and medical cases used by early Mahoning county physicians, as well as up-to-date equipment.

Old and new drugs were displayed; cancers and tumors were exhibited; and the history of nursing was portrayed in a display of small models dressed in the uniforms of the various periods.

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ACTIVITIES OF COUNTY SOCIETIES

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

ADAMS

Dr. James Shaw, Cincinnati, addressed the Adams County Medical Society meeting in West Union, August 28, on the subject "Some Aspects of Pulmonary Tuberculosis". After the morning program, dinner was served at the home of the secretary of the society. Dinner speakers were Dr. Ralph W. Eddy, Cincinnati, who discussed "Carcinoma of the Fundus and Cervix Uteri", and Dr. Robert H. Kotte, Cincinnati, who talked on the Child Health Survey.—Hazel L. Sproull, M. D., Secy.

CLINTON

Dr. Leo S. Friedman, Cincinnati, addressed the Clinton County Medical Society meeting at the General Denver Hotel in Wilmington, September 3. Dr. Friedman's subject was the "Child Health Survey on Services". The survey project was approved by the society.—R. W. DeCrow, Secy.

HAMILTON

The first regular meeting of the 1946-1947 academy year of the Academy of Medicine of Cincinnati was held September 17 in Cincinnati. Dr. David A. Tucker, Jr., delivered the annual address of the retiring president, and Dr. Charles E. Hauser, incoming president, the inaugural address. The new officers of the academy were installed.—Bulletin.

Second District

(COUNCILOR: H. C. MESSENGER, M. D., XENIA)

Dr. Karl Figley, Toledo, secretary of the American Academy of Allergy, spoke on the subject "Some Considerations Regarding Allergy" at the September 19 meeting of the Clark County Medical Society, held at the Hotel Shawnee in Springfield.—Bulletin.

MIAMI

The 1946-1947 season of meetings of the Miami County Medical Society began September 6 with an illustrated lecture on "The Present Status of Thiouracil in the Treatment of Goiter", presented by Dr. Robert S. Austin of Dayton. The meeting was held at the Piqua Memorial Hospital.—G. A. Woodhouse, M.D., Secy.

Fourth District

(COUNCILOR: A. A. BRINDLEY, M. D., TOLEDO)

LUCAS

After several years of inactivity, the Academy of Medicine of Toledo and Lucas County Bowling League is again being organized. The members will bowl at 2 p. m. each Thursday at the Colony

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Alleys in Toledo. Dr. C. J. Czarnecki is directing the league.—Bulletin.

Fifth District

(COUNCILOR: FRED W. DIXON, M. D., CLEVELAND)

ASHTABULA

The Ashtabula County Medical Society held its regular meeting September 3 at Peras, Geneva-on-the-Lake. Dr. W. S. Duncan, Cleveland, talked on treatment of fractures. Announcement was made of the survey on child health services of the American Academy of Pediatrics.—News clipping.

CUYAHOGA

The regular meeting of the Academy of Medicine of Cleveland was held September 20 at the Medical Library Auditorium in Cleveland. The speaker was Dr. Carl V. Moore, professor of medicine, Washington University School of Medicine, St. Louis. His subject was "An Appraisal of Radioactive Phosphorus in the Treatment of the Blood Dyscrasias". Dr. Moore was a guest speaker at the centennial anniversary meeting of the State Association in May.

The Academy bowling season opened September 10 at the Linsz Recreation Inc., in Cleveland.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M. D., AKRON)

MAHONING

A motion picture film on "Hematology" was shown at the September 17 meeting of the Mahoning County Medical Society, held at the Youngstown Club, Youngstown. Speaker for the October meeting is Richard Harold Freyberg, M. D., New York City, and for November, Robert S. Palmer, M. D., Boston.—Bulletin.

SUMMIT

Dr. Vinton E. Siler, associate professor of surgery, University of Cincinnati College of Medicine spoke on "Infections of the Hand" at the September 3 meeting of the Summit County Medical Society at City Hospital in Akron.—Bulletin.

Eighth District

(COUNCILOR: ARTHUR J. TRONSTEIN, M. D., NEWARK)

LICKING

The first fall dinner meeting of the Licking County Medical Society was held at Granville Inn, Granville, September 27. The speaker was Dr. R. P. Reynolds, chief of the surgical service, Grace Hospital, Detroit. His subject was "Gastrectomy for Duodenal Ulcer".—News clipping.

MUSKINGUM

The September 4 meeting of the Muskingum County Academy of Medicine was held at the University Club in Zanesville. Two physicians from the State mental hospital in Cambridge and a representative of the Veterans Administra-



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tion spoke at the meeting.—Beatrice T. Hagen, M.D., Secy.

Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M. D., SANDUSKY)

LORAIN

Dr. William Klann, Wellington, spoke on "Diabetes" at the September 10 meeting of the Lorain County Medical Society, held at the Castle-on-the-Lake, Lorain.—L. H. Trufant, M.D., Secy.

WOMAN'S AUXILIARY NEWS

By MRS. FRED W. BROSIUS, MIDDLETOWN
Chairman, Publicity Committee

ASHTABULA

The first meeting of the Woman's Auxiliary to the Ashtabula County Medical Society was held at the Nurses' Home, Rogers Place, at 8 p.m., Tuesday, September 10.

Mrs. A. M. Mills, president, conducted the business session, at which time a constitution and by-laws was adopted. Reported by Mrs. S. A. Burroughs, 3323 Schenley Rd., Ashtabula, chairman of press and publicity.

BUTLER

The Woman's Auxiliary to the Butler County Medical Society planned a buffet supper for members and their families, Sunday, September 15, at the home of Dr. and Mrs. Azel Ames, Hamilton.

Mrs. J. A. Mackie, chairman of arrangements, was assisted by the following officers: Mrs. C. J. Chamberlin, Mrs. Ross Hill, Mrs. Edward Keating, Mrs. E. T. Storer, Mrs. W. F. Vinnedge, Mrs. Kenneth Smith, Mrs. David Gerber, and Mrs. Ames.

ROSS

Fourteen members of the Woman's Auxiliary to the Ross County Academy of Medicine met for dinner at Allyn's Dining Room, Thursday evening, September 5. Mrs. John Franklin, vice-president, presided in the absence of Mrs. H. M. Crumley.

Following dinner, the group adjourned to the home of Mrs. Glen Nisely for the business meeting. Mrs. E. H. Artman gave a report of the State Convention at Columbus, and Mrs. Franklin reported on the National Convention held at San Francisco. Mrs. M. D. Scholl is chairman of press and publicity.

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The State Medical Board has issued licenses to practice medicine and surgery in Ohio to the following physicians, through indorsement of their licenses to practice in other states: May 7, 1946—Alan B. Adam, Cleveland, Univ. of Colorado; Wm. H. Baldwin, Johnstown, New York Med. College; Evelyn M. Ball, McArthur, Med. College of Virginia; James C. Beesley, Columbus, Univ. of Michigan; Robert A. Bruce, Dayton, Univ. of Louisville; John F. Burton,

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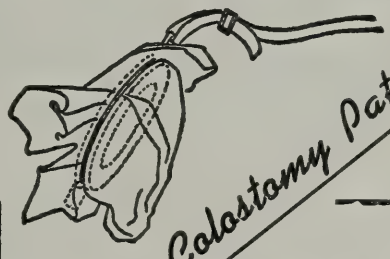
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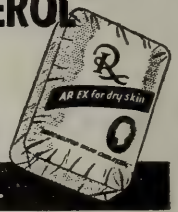
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American Democracy and American Medicine

EDWARD J. McCORMICK, M. D.

ON May 14, 1787, General George Washington called to order the Federal Convention whose deliberations made the United States of America the greatest nation in the world. There were 55 men in this historic and distinguished group. Twenty-nine were university men. Many professions and avocations were represented. Among those seated in the room on Chestnut Street, in Philadelphia, were Benjamin Franklin, Alexander Hamilton, the Morrises, and James Madison, of Virginia.

Few Americans in this day and age pause to recall that the first Federal Convention resulted from the desire of our forefathers, who pioneered in America, to be free, to seek equal opportunity, and to escape persecution, racial hatred and discrimination, serfdom and regimentation.

From this gathering of liberty seeking leaders came the Constitution of the United States of America. The first ten amendments were introduced by Madison and were referred to as "The Bill of Rights" giving to Americans for all time, freedom of speech, freedom of the press, religious freedom, and the right of peaceful assemblage and other freedoms and rights little appreciated by many citizens of the present day United States of America. There are many who have forgotten that we hold certain truths to be self evident: "That all men are created equal and endowed by their Creator with certain inalienable rights and privileges and that among these are Life, Liberty and the Pursuit of Happiness!" Many have forgotten that to secure these rights, governments are instituted among men, deriving their just powers from the consent of the governed. Yet, there are those in our present day who feel that man in America should once again become the pawn of dictatorial government and that "government by the people and for the people" should be relegated to the scrap heap.

Democracy as we know it has made the youngest nation in the world the greatest nation in the history of the world in 157 years.

American Democracy has given to us the greater share of the world's gold, telephone and telegraph facilities, motor cars, railroads, bonds, stocks, and insurance policies. American Democracy has produced the best schools and universities in the world, the best hospitals and clinics, the finest museums, the greatest lawyers, doctors, and engineers. Democracy has made possible Ford, Firestone, Edison, Carnegie, and

The Author

● **Dr. McCormick, Toledo, Ohio, is a graduate of St. Louis University School of Medicine, 1915; member, Founders Group, American Board of Surgery; fellow, American College of Surgeons; chairman, Council on Medical Service, American Medical Association; chief of staff, St. Vincent's Hospital; director of surgery, Maumee Valley Hospital; and assoc. surgeon, Toledo Hospital.**

Presented at the annual meeting of the Ohio State Radiological Society held in conjunction with the Centennial Anniversary Meeting of the Ohio State Medical Asociation at Columbus, May 7-9, 1946.

Knudson. Democracy has given us great industries and made it possible for us to finance Great Britain and Russia and other allies in World War II. It made possible lend-lease. It won World War I and World War II. Democracy and private enterprise have produced the greatest Army, the greatest Navy, and the greatest Air Corps the world has ever seen. American Democracy has placed labor on a plane never before occupied by the workers in any other part of the world. The United States in a century and a half has become the best fed, best clothed, best housed, most comfortable nation in the history of mankind.

LIBERTY FOR SECURITY

For some years the termites of socialism, communism, and foreign ideologies, aided and abetted by hand-shaking, vote-seeking politicians, have been gnawing away at the foundation of our greatness and their battle cry has been security! They have tried to trade liberty for security with the aim and purpose of regimenting the American people and finally giving them neither liberty nor security.

These trends have been advanced by un-Americans in our schools and colleges, in our City, State, and Federal governments. We have tolerated the Workers Alliance, the German Bund, the Fascist Black Shirts, the American League for Peace and Democracy, the America First organization, and communist inspired strikes.

Frederick Hayek, author of "The Road to Serfdom" has this to say: "——Nothing is more fatal than the present fashion among intellectual leaders of extolling security at the expense of freedom. It is essential that we should re-learn frankly to face the fact that freedom can be had only at a price and that as individuals we must be prepared to make material sacrifices to preserve our liberty. If we want to retain this, we must regain the conviction on which the rule of liberty in Anglo-Saxon countries has been based and which Benjamin Franklin expressed in a phrase applicable to us in our lives as individuals no less than as nations: "Those who would give up essential liberty to purchase a little temporary safety deserve neither liberty nor safety."

WOULD REGIMENT PROFESSIONS

In the front ranks of those who would preserve democracy stands the American Medical Profession. Opposed to the medical men of America are the social planners, job creators, and professional "do-gooders" who feel that the men and women of America, the greatest of nations, must be cared for by the government from womb to tomb, that American men and women can not meet and should have no responsibilities. They propose that medical men and women, dentists, nurses, and hospital workers should be regimented and that we whose fathers and mothers fled from the persecution and regimentation of other countries should forsake the American way of life, American democracy, and adopt as our own, certain old world policies and techniques which are totalitarian and communistic. Bismarck in 1883, in Germany, sold his people on the principle of social security and socialism and sowed the seed which brought forth Hitler and Goering and Goebbels and led to the destruction of the German Empire.

The Socialization of Medicine as outlined in the Truman Health Program and the Wagner-Murray-Dingell Bill is a threat to American democracy. There are many reasons for this statement but two are of great importance.

THREAT TO DEMOCRACY

First: The acceptance of socialized or political medicine by the American legislators and the American people is the first step in the direction of centralized government, loss of state's rights, and governmental control of the daily lives of the people, and can only lead to federal control of other professions and all business endeavor. It seems paradoxical to presume that a free people should ever seriously consider the adoption of such a proposal. It is backed, however, by a great army of social uplifters and job seekers and is being presented to the people with a salesmanship, which stresses security, and no mention is made of the fact that sooner or later the taxpayer and the so-called common man will sacrifice his liberty and will become a pawn to be moved here and there by a dictatorial government. When the government has decided who his doctor shall be and how many treatments he may have and has forced him to certify for public record to the diseases which he or his wife may have had in the past, the same government will soon specify his lawyer, his carpenter, his plumber, and his vacation periods, if any, and it is likely that there may be few if any leisure hours for the worker if governmental groups can raid his pay check and abstract this or that percentage for this or that purpose. One can foresee in the present security trends, a people devoid of independence, lacking in initiative and facing to Washington for religious direction and reading government newspapers and listening to government radio programs! Some of our social workers and economists have forgotten that the only worthwhile charity is the charity which makes men and women independent. Creation of dependency in America was never intended when it was written, "that all men are created equal". America was born to be the land of opportunity and not the land of dependency! When I speak against the control of medicine by the government I am not

thinking of medicine alone but of the sons and daughters of "the free and brave" who are entitled to opportunity and not economic or political slavery.

WOULD MEAN THIRD-RATE MEDICINE

Second: The great objection to socialized or political medicine as proposed by President Truman and Mr. Wagner, Mr. Murray and Mr. Dingell is the fact that such a program will take from the American people the best medical care in the world and give them in return a type of medical service which is third rate by comparison. There can be no argument against the statement that government control will definitely lower the quality of medical care now available to the American people. In addition, the medical care under federal control will be costly! The most conservative mathematicians estimate the bill at not less than four billion dollars a year. There are many who feel that the cost will far exceed this estimate. It is safe to say that whatever payroll deduction is made, four per cent from employer and four per cent from employee, will be doubled or trebled as the list of government employees, who boss the doctor and the patient, grows from an estimated three hundred thousand to a much larger number. Beyond all question of doubt, the army of social workers and investigators under the Surgeon General of the United States Public Health Service will in terms of employees and manpower outgrow the peacetime Army and Navy of the United States.

Much has been alleged by the proponents of socialized or political medicine to support their argument for this type of legislation but nothing has been proven!

MEDICAL CARE NOT LACKING

Much has been said regarding medical neglect. In 30 years of surgical practice I have never encountered a person who suffered for lack of medical care except in a few instances where medical care was not sought or desired. There are very few places in this great country of ours where medical care is unavailable. Only a small percentage of our people live more than 30 miles from a recognized hospital! Furthermore, the hospitals and physicians can never be accused of denying medical care to the indigent or the low income group. The medical profession has brought into being the great charity institutions of our country, magnificent hospitals where the best in medicine and surgery awaits the poor and those who can not pay a fee. Every hospital in the country is at this very moment caring for people who are charity patients or part-pay patients and the doctors treat them and operate upon them because there is a joy in service and a spiritual stimulation in doing good for others. Many millions of dollars are contributed each year by physicians to patients who can not pay for the services rendered. Presumably these millions would be returned to the medical profession under a federal program. There should be no charity patients if the government becomes the physician of the people, although the Wagner-Murray-Dingell Bill does not so specify. Regardless of the 365 or more millions which should be returned to medical men each year for the care of the indigent, such a program and the eight-hour day and five-day week which should go into effect for doctors, we in medicine would rather be free. We wish to keep America a free country!

Selective Service statistics* have been frequently cited as a reason for a government health program. Senator Pepper's interim report points out that 4,217,000 were disqualified for service in the Armed Forces. It is not pointed out, however, that 444,800 were disqualified because of total blindness, deafness, deaf mutism, and that some were armless or legless. Nor is it stressed that 701,700 were rejected for mental diseases or that 582,100 were refused a uniform because of mental deficiency, the idiots, the imbeciles, the morons. Three hundred and twenty thousand were rejected because of club feet, paralysis and congenital deformities. Medicine, as it is now practiced in this or any other country or under any conceivable plan, could not change these figures or better the lot of these 2,048,600 unfortunate people. An additional 280,000 were rejected for syphilis, despite the fact that treatment for this disease is offered free by Public Health authorities in every state and county in the country. One must pause to wonder if a little religion and observance of the moral law might not be in order. Certainly political medicine is not the answer . Two hundred and twenty thousand were rejected for hernia, a congenital defect, easily curable by surgery. Many refuse surgical intervention because of fear, religious belief, and other causes, and among these causes during the war was fear of induction. Surgery for hernia can be obtained in hundreds of hospitals and without cost to the deserving and for a small fee for those who can afford to pay. One hundred sixty thousand were rejected because of eye trouble, largely congenital and not caused by lack of medical care. Thus an additional 660,000 or a total of 2,708,600 are eliminated from the original figure of 4,217,000, leaving 1,508,400, and in my opinion this balance of prospective service men and women were not denied service because of lack of medical care but rather because physical requirements of the United States Armed Forces were the highest in the world and in all probability these people

* The figures on draft rejections, death rates and sickness expectancy in England and Germany appeared in a paper written by Dr. Lowell S. Goin, of Los Angeles.

would have been doing front line duty had they been citizens of any other country. Likewise it is fair to say that a large proportion of the remaining number would have been fit for service if their standards of living had been higher and health education available. Actual lack of medical care is a small factor.

ENGLAND'S REJECTION RATE HIGHER

It is interesting to note that in England, where socialized medicine has existed for some years and where Army physical requirements are much lower than those in America, that the rejection rate was 50 per cent as compared to 38 per cent in America. It is also interesting to note that the death rate in England and Germany, under compulsory health insurance, is higher than in America. The proponents of compulsory health insurance do not point out that in prewar Germany the government-insured people had a sickness expectancy of 200 per cent as compared to 20 per cent in the United States. Nor are we told that in countries where compulsory health insurance is in existence that the total number of days which an individual is sick doubles the average number of days that an individual is sick in the United States.

SURGEON GENERAL WOULD DICTATE

A recent study made by investigators who visited thousands of doctors revealed that more than 90 per cent have no favor for compulsory health insurance. Doctors feel that the enactment of compulsory health legislation would undermine and destroy our system of medicine and medical education. It would make the Surgeon General the dictator over all doctors, hospitals, and patients. The Surgeon General could specify who is and who is not a specialist. He could tell a doctor how many people he could serve and which hospitals would be entitled to participate. Catholic, Jewish, and Protestant hospitals, intimately associated with certain religious principles, might find it necessary to modify their practice to meet the dictates of government agencies. Bureaus instead of physicians under a system of government standardization would decide who could have babies and how many and insist on therapeutic abortion and sterilization. With socialization of medicine there comes not only the probable loss of freedom in the United States and the departure of Democracy but also the likelihood of practices now abhorent to all ethical doctors, whether Catholic, Protestant, or Jew.

American Medicine has met the challenge. Blue Cross Hospital plans now insure more than twenty-two million people. Through industry and private insurance companies forty million people are protected, in whole or in part, against accident and illness. Several million are covered by voluntary prepayment sickness insurance. Such voluntary plans are now active in 25 states and it is expected that similar plans will be in operation in 15 additional states before the end of 1946. It is the aim and purpose of the Council on Medical Service and Public Relations of the American Medical Association to have such plans in all states in the very near future. There would seem to be not the slightest need for building another great government bureau to further over-burden the taxpayer and eventually lead us into state socialism or communism.

SUPPORT CONSTRUCTIVE LEGISLATION

American doctors have indorsed such proposed legislation as the Hill-Burton Bill and favor other progressive legislation and appropriations which give to the American people more hospitals and health centers, and which will extend and improve medical research and education. We favor federal aid to states where need is demonstrated but we are unalterably opposed to regimentation of medicine, dentistry, labor, or any other group.

Much of our illness is not dependent on medical science but on the need for higher standards of living extended to a greater number of people. Nutrition, housing, clothing, and recreation are as essential to health as good medicine, and no amount of political or socialized medicine will counteract the lack of these essentials.

The doctor, as the priest or minister, has a sacred duty to perform. No government agent, in a Democracy, has any right to share the privileged communications which are tendered the physician of the soul or the physician of the body.

DOCTORS VOLUNTEERED

Sixty thousand doctors volunteered their services in World War II and sixty thousand carried the burden night and day on the home front. Fifteen million young Americans entered the Armed Services and fought and died for individual rights and freedom. We must not now, in false zeal, give away the very things they fought and died for! Let us keep America free!

Let us give to all equal opportunity and under no circumstances permit independence to be replaced by dependence. Let us stand forever opposed to false altruism which would weld from a promised security, chains to shackle forever the people of America.

May the supreme diety bless the poet who wrote the verse which has been referred to as the G.I.'s litany—

> "God of the hidden purpose
> Let our embarking be
> The prayer of proud men asking
> Not to be safe, but free."

Advances in Electro-Coma Therapy of Psychoses

JOSEPH L. FETTERMAN, M. D.

ELECTRO-COMA (shock) therapy has clearly established its remarkable usefulness in the space of some seven years since its introduction in psychiatry. The therapeutic worth of this method has been substantiated by its wider use, and the indications, the prognosis, and even the techniques, have been improved and modified. It is the purpose of this paper to point out some of the advances and the modifications of this mode of treatment as reflected by the current literature, papers read in the Convulsive Section of the American Psychiatric Association May 30, 1946, and especially the author's personal experience.

The Author

● Dr. Fetterman, Cleveland, Ohio, is a graduate of Western Reserve University School of Medicine, Cleveland, 1921; diplomate, American Board of Neurology and Psychiatry; fellow, American Psychiatric Assn.; assistant clinical prof. of Nervous and Mental Diseases, (on leave of absence); director, Neuropsychiatric Institute of Cleveland.

INDICATIONS

A vast experience by an ever-widening circle of psychiatrists has demonstrated that electro-coma therapy is the present method of choice in illnesses characterized by severe depression.[1] Although the shock therapies were introduced primarily as a therapeutic measure for the schizophrenias, time has shown that such techniques are of distinct value in the depressive illnesses. Apparently in depressions there is a reversible component, physical in nature, which is influenced to such a favorable degree that the total personality shows improvement. Thus electro-coma has proved to be almost a specific for the depressed phase of manic-depressive psychoses and the involutional melancholias. It exerts a beneficial influence upon the schizo-affective disorders and has been used with favorable results to some degree in the psychoneurotic depressions.

In the depressed phase of manic-depressive psychosis, the recovery rate is high, figures of improvement ranging from 70 per cent to 95 per cent. Likewise, patients with involutional melancholia, who in years past continued to suffer with overwhelming symptoms of somatic distress and self-accusatory ideas, can now be restored to relatively good health in the matter of weeks or months. True, there are relapses early or late, but even the recurrence of symptoms can be favorably handled. Of course, there are a small number of patients who do not respond to these methods.

Electro-coma therapy is of value also in the schizophrenias provided the case is not chronic and especially in those cases loaded with affect. Indeed, so remarkable is the improvement in some schizophrenic patients that one is inclined to question the diagnosis. Rather, it is our experience that the schizophrenias of later life in individuals who had attained maturity are of a different significance than those schizophrenias which begin in adolescence among persons whose development towards adult thinking and living was deficient. The patients whose symptoms begin early and who fit the original concept of dementia praecox, respond little, if at all, to shock therapy even though temporary improvement in some of the symptoms is readily obtained.

The use of the electro-coma techniques for the psychoneurotic depressions is as yet a debatable matter, although Moriarty and Weil[2] have found this technique helpful, particularly when using a brief course of treatment to render the patient more amenable to psychotherapy. Hamilton[3] similarly reported favorable use of combined electro-shock and psychotherapy in psychoneuroses.

MODIFICATIONS IN THE PRETREATMENT PROCEDURES

During the past few years, several distinct improvements have been introduced largely to help the tense, anxious patient. Impastato[4] has shown the value of the use of sodium amytal intravenously before each shock treatment is given. My personal experience corroborates Impastato's findings. A dose of sodium amytal of 3-3/4 gr. to 7-1/2 gr. intravenously given several minutes before the electric current is passed induces a state of drowsiness or even cheerfulness. Fear is allayed and resistance is overcome. As a consequence, those patients who had previously dreaded the treatment because of marked anxiety and intense fears, become cooperative individuals as willing to receive the treatments as the average patient. For, as a

Presented before the Section on Nervous and Mental Diseases at the Centennial Anniversary Meeting of the Ohio State Medical Association, Columbus, May 7-9, 1946.

rule, many patients accept electro-coma therapy quite willingly even though with some reluctance.

Rubinstein[5] has used pentothal sodium not only to calm his patients but to produce complete sleep just before the treatment is given. He proposed a wider use of this method for it removes all apprehension.

There has been the impression that the use of such sedatives might inhibit the convulsive response. My personal experience has been that the use of sodium amytal either as oral medication or as intravenous pretreatment therapy did not interfere with a major convulsive reaction. It is my custom to increase the dose of the current slightly to compensate for the possible anticonvulsant qualities of the drug used.

Another minor improvement in the pretreatment handling of patients is the giving of food. It had been customary to omit all food for hours before treatment. During the past 18 months, I have permitted my patients to have a light breakfast such as fruit juice and coffee, provided this was given some two hours before treatment. We have encountered no untoward reactions and have noticed a more comfortable physical state.

MODIFICATIONS IN THE TECHNICAL PHASES OF THE TREATMENT

Although, during the earlier years of electro-coma therapy, some authors believed that minor reactions, so-called petit mal, might be beneficial, accumulated experience leaves no doubt about the need for major (grand mal) responses. Experienced therapists avoid minor reactions and employ a current of sufficient dosage to bring about a major reaction promptly at each session.

Some years ago, a modification of the apparatus, referred to as unidirectional current, was introduced. Wilcox[6] reported his experiences with 23,000 treatments at Traverse City State Hospital. He believes that this modification is an improvement over the standard technique. Weil[2,7] has introduced this technique to us and we have found that, by the use of this method and the application of one of the electrodes over the motor area instead of the customary bitemporal placement, a major reaction can be obtained with a smaller dosage of electricity. We are conducting a series of memory tests (Katz) which will be reported later, but which tend to indicate less memory disturbance with the unidirectional method than with the standard current administered bitemporally.

To soften the convulsion intocostrin is being used more widely throughout the country. Bennett's[8] demonstration of the relative safety and protective usefulness of this medication has been borne out. Thus, in many clinics intocostrin is used routinely or in patients who have developed back complaints. Certainly the occurrence of pain in the back due to muscular or bone trauma demands the employment of intocostrin if further treatments are to be given.

COURSE OF TREATMENT

Experience has shown that electro-coma therapy is relatively safe and that one need not hesitate to use an adequate number of treatments. Originally the aim was a brief course. Though brevity of the treatment course is desirable, a lasting recovery is a more significant goal.

For the depressed patients, the average number of treatments in the primary course is 12, but the number is to be adjusted to each individual. I have seen lasting recovery with 4 or 6 treatments and then again I have used 20 to 30 electro-coma reactions in a depressed patient before enduring results were obtained. It is my custom to give regular treatments until there is distinct improvement. Then several additional reactions are given. After this, periods of vacation from treatment are allowed, during which time the patient is interviewed and psychotherapy given. Any indication of a downward course is a signal for resumption of treatment.

As a rule, the schizophrenic patients require more shock reactions. Indeed, our results are similar to those of Kalinowsky,[9] who insists that 20 or more reactions have to be obtained if the schizophrenic patient is to show any significant sustained improvement.

Treatment is given both in a primary course and in subsequent "maintenance" doses. It is the custom in most clinics to give treatments every other day at the beginning. However, in patients who are extremely tense and desperate, it is better to administer daily reactions to the point where the patient is more calm. When he or she is improved, then the treatments may be spaced at longer intervals.

Most patients exhibit considerable improvement as a result of the initial course of 10, 15, or 20 treatments and they are able to resume normal activities. In some persons this recovery does not continue and there is a recurrence of symptoms. It is possible to bring about improvement by the use of one or two treatments only at such intervals as the symptoms warrant. In some patients a "maintenance" dose of one treatment a week, in others, one a month, or even at less frequent intervals is necessary. For instance, one of my depressed patients received one or two maintenance treatments every two or three months over a period of a year following his initial improvement. He is now apparently well and has not required any further therapy for the past 15 months.

Although every psychiatrist respects the seriousness of this procedure, yet we do not hesitate

to use a larger number of treatments than was originally considered advisable. In stubborn cases one may employ 30 to 50 treatments or more if necessary. Indeed, Perlson[10] reported the successful use of 248 treatments in a difficult schizophrenic patient.

AMBULATORY TREATMENT

Electro-coma therapy was originally a hospital procedure, and practically every patient was placed in a hospital for this purpose. Yet it was found that a considerable number of patients could be satisfactorily treated in an ambulatory manner (Myerson,[11] Wender,[12] Impastato[13] Patry[14]). During the past few years, because of the bed shortage, it was impossible to hospitalize all those who needed electro-coma therapy and thus many physicians resorted to the ambulatory method. It was found that the results were just as good, if not better, when patients were permitted to remain at home.

The advantages of the ambulatory technique are many. The patient and his family save prestige since, in the past, electro-coma therapy was given to a large extent in sanitaria and mental hospitals. Indeed in some communities it was necessary to probate the patient by such antiquated methods as a lunacy inquest so that he might obtain the benefits of therapy. Today, such patients can be handled in a satisfactory manner in a well-staffed and well-equipped doctor's office or in outpatient clinics.

The ambulatory method saves money for the family, spares nurses' time and hospital beds for more critically ill patients. Then, too, many patients are able to continue some activity at home and in professions in an environment that is more conducive to recovery than the restricted, closed ward atmosphere of many hospitals. It is remarkable that patients who receive treatments in the morning may do housework, play golf, and even continue lucrative employment the same afternoon or on the day between treatments.

The disadvantages of the ambulatory method are the added responsibility of the family and the hazard of suicide. These disadvantages can be met by a careful selection of patients. It is unwise to begin ambulatory therapy in a patient unless there is an understanding and capable family which is willing to assume the responsibility of looking after the patient. They must provide companionship, escort the patient to and from the place of treatment, sit with him during the recovery period. Most families are happier when they participate actively in such a program than when they remain passively at home, anxious and worried about what may be happening in a mental hospital.

As regards the hazard of suicide, several precautions are necessary. First is the rule that any patient whose symptoms are desperate and who has expressed strong suicidal tendencies is safer in a hospital if a bed can be obtained. Secondly, if hospitalization is not possible, then the family must provide constant vigilance and remove such drugs, implements, and dangers as might invite suicidal intent.

If there is a careful selection of patients, it is possible to complete a course of electro-coma therapy satisfactorily in a very high percentage of cases. I have been able to treat some 50 per cent of patients who required such therapy, in an ambulatory fashion.

AFTER CARE

Immediate Attention: There have been no particular changes in the method of handling patients during the period of awakening after the convulsive reaction. Most patients regain consciousness gradually after a period of deep sleep and, after the confusion leaves, return to their usual or improved states of health. There are some, however, who are wildly overactive, thrashing about, or crying out loudly. Such disturbed post-convulsive behavior can be prevented by the use of sodium amytal preliminary to the treatment or, as has been suggested by Baumoel,[15] immediately after the convulsion is over.

Follow-Up Care—Psychotherapy: Though electro-coma treatment brings about a substantial improvement in the patient's mood, yet it is advisable to supplement this technique with psychotherapy. The individual has both internal conflicts and interpersonal problems. It is necessary to assist him to handle these problems satisfactorily so that he can make a better adjustment to life. There are some patients whose point of view is so tremendously and favorably changed by treatment that they are able themselves to cope with previously distressing problems in a healthful manner. They need little, if any, special treatment. There are others, however, who need considerable guidance and they deserve follow-up psychotherapy.

NOTE ON MODE OF ACTION OF ELECTRO-COMA THERAPY

A recent experience is of considerable interest in throwing some light on the mode of action of electro-coma therapy. A patient of 60 who had been a keen, dynamic individual, became depressed in the fall of 1944. He showed loss of confidence, insomnia, loss of weight, self-depreciation, and agitation. He was placed in a hospital where it was planned to observe him with a view towards a course of electro-coma therapy. The study revealed a history of an attack of coronary thrombosis several years previous and electrocardiographic evidence of residual changes. The patient's apparent improvement during the period

in the hospital and the history of coronary disease caused us to delay electro-coma therapy.

He was permitted to go home and he showed a moderate improvement. Then one day he was missed in the home and was found unconscious in his automobile with the motor running. He remained in a state of coma for 72 hours and then gradually returned to consciousness. He made a physical recovery.

However, though there was recovery in a physical sense, this patient did not regain his mental capabilities. He had a residual loss of memory and judgment. He would glance at a newspaper but could not comprehend what he read. He might read a letter or greet a visitor but would completely forget the contents of the letter or the nature of the visit within five or ten minutes afterward. Although he looked at the newspapers and listened to the radio, he did not know that the war was over. He was also unable to remember in what professions members of his family were engaged. When given a series of numbers, he could not repeat more than two or three digits.

The carbon monoxide had produced a serious encephalopathy with considerable permanent damage to the cortex. The intellectual capacities of this man had been destroyed. Yet he remained depressed. He cried, spoke with a feeling of hopelessness about the future, and expressed the wish to die.

The effect of electro-coma therapy is in another direction. There is frequently a dulling of memory and in rare instances a temporary serious disturbance in judgment. However, the mood is frequently altered from one of dejection to one of cheerfulness and even elation. Even when the mental functions are normal, the mood remains elated. Electro-coma therapy produces its benefit not merely by temporary destruction of cortical function, although there is some temporary damage to certain functions as revealed by the electro-encephalogram; its benefit is achieved also through some stimulating effect on the deeper diencephalic centers.

In contrast to the above cited case, I can mention numerous individuals whom I treated in 1941 and 1942 for severe depressions. These people are now well and capable of continuing in jobs that require new learning, concentration, decision, and responsibility. A considerable number of these patients include executives, lawyers, doctors, nurses, engineers, who have continued to maintain physical well-being and mental efficiency for years after the treatment program was completed.

CONCLUSION

1. A vast experience by an ever-widening circle of psychiatrists has demonstrated clearly the worth of electro-coma therapy of psychoses.

2. This therapy is of distinct value in those psychoses in which depression is a significant feature.

3. The course of treatment is now longer than when the method was first used and an initial series of treatments is sometimes followed by occasional "maintenance" doses.

4. Pretreatment medication is commonly employed to alleviate tension and anxiety. Sodium amytal and even sodium pentothal are employed for this purpose.

I wish to thank Dr. M. D. Friedman, Associate Director, and Dr. A. A. Weil, Research Director, of the Neuropsychiatric Institute of Cleveland, for their collaboration in the treatment program of electro-coma patients.

5. Electro-coma therapy can be administered as an ambulatory treatment in some 50 per cent of patients. A careful selection of patients must be made on the basis of type of illness and the responsibility of the family.

6. Electro-coma therapy is effective without any serious permanent brain damage.

BIBLIOGRAPHY

1. Fetterman, J. L.: Electro-Coma Therapy of Psychoses. Ann. Int. Med., 17:775, Nov., 1942.
2. Moriarty, J. D., Weil, A. A.: Healing Mechanisms in the Shock-Treated Neurotic Patient. J. Nerv. and Ment. Dis., 101:205, Mar., 1945.
3. Hamilton, D. H.: Use of Electric Shock Treatment in Psychoneurosis. Paper delivered at the annual meeting of the American Psychiatric Association, Chicago, May 30, 1946.
4. Impastato, D. J., Bak, R., Frosch, J., and Wortis, S. B.: Modification of the Electrofit—1. Sodium Amytal Am. J. Psychiat, 100:358, Nov., 1943.
5. Rubinstein, H. S.: Sleep-Electro-Shock Therapy. Paper delivered at the annual meeting of the American Psychiatric Association, Chicago, May 30, 1946.
6. Wilcox, P. H.: Electroshock Therapy: Review of Over 23,000 Treatments at Traverse City State Hospital Using Unidirectional Currents. Paper delivered at the annual meeting of the American Psychiatric Association, Chicago, May 30, 1946.
7. Moriarty, J. D., Weil, A. A.: Combined Convulsive Therapy and Psychotherapy of the Neuroses. Arch. Neurol. and Psychiatry, 50:685, Dec., 1943.
8. Bennett, A. E.: An Evaluation of the Shock Therapies. Diseases of the Nervous System VI, 1, Jan., 1945.
9. Kalinowsky, L. B.: Electric Convulsive Therapy, with Emphasis on Importance of Adequate Treatment. Arch. Neurol. and Psychiat., 50:652, Dec., 1943.
10. Perlson, J.: Psychologic Studies on a Patient Who Received Two Hundred and Forty-Eight Shock Treatments. Arch. Neurol. and Psychiat., 54:409, Nov., Dec., 1945.
11. Myerson, A.: Experience with Electric Shock Therapy in Mental Disease. New England J. Med., 224:1081, 1941.
12. Wender, L., Balser, B. H., Beres, D.: Extra-Mural Shock Therapy. Am. J. Psychiat., 99:712, Mar., 1943.
13. Impastato, D. J., Frosch, J., Almansi, R. J., and Wortis, S. B.: The Electrofit in Depression, Comparison of Hospital and Privately Treated Patients. New York State J. of Med., 45:179, Jan., 1945.
14. Patry, F. L.: Abridged Technique in Ambulatory Electro-shock Therapy. Diseases of the Nervous System VI, 1, Jan., 1945.
15. Baumoel, S.: Prevention of Postconvulsive Hyperexcitability in Electro-Shockk Thrapy. Diseases of the Nervous System, 7:151, May, 1946.

The concept that essential hypertension results from primary kidney disease has stimulated the use of renal extracts but they have not attained a practical clinical use at present. The results reported by the surgeons advocating sympathectomy are encouraging but many years of observation are necessary to determine the effect of this procedure.—Edward W. Cannady, M.D., The Illinois Med. Jrnl., Vol. 90, No. 3, Sept., 1946.

Coronary Heart Disease

A. B. BROWER, M.D.

THE development of the clinical recognition of coronary disease has been a very slow one. Claudius Galen (131-201 A.D.) is credited with originating the term coronary, meaning crown. He thought that the heart was nourished through the coronary veins. His fallacious tenets prevailed for nearly fourteen and one-half centuries. Galen thought that nutrient blood came from liver through the vena cava and veins of the body and that the right side of heart received the blood through diastolic aspiration. Some of the blood passed through septum of heart through invisible pores into left ventricle and part of the blood passed to lungs by way of pulmonary artery.

Lucius Seneca who lived from 4 B.C to 65 A.D. described his own symptoms which were classical of angina. Beautiful drawings of the coronary vessels were made by Leonardo de Vinci (1452-1519). William Harvey (1578-1657) in 1628 published his famous work on the heart and circulation, and in this he recognized the coronary circulation and its role in heart nutrition. Jean Riolan in 1649 dissected the coronaries and confirmed the work of Veselius and Fallopius, but refused to accept the teachings of Harvey. He said if dissection was in disagreement with the teachings of Galen then nature had changed since Galen's day!

Richard Louer in 1669 brought out the results of his investigation with coronary circulation. He demonstrated the anastomosis between the coronary arteries. He was, by the way, the first to perform direct transfusions of blood from one animal to another. Pierre Chirac (1650-1732), of France, ligated a coronary artery and found that it resulted in sudden cardiac standstill.

In the 18th century, Bonet associated coronary disease with serious illness. Postmortem findings verified his observations. Raymond Viensseus in 1715 accurately described the distribution of the coronary vessels and gave the first correct description of the left ventricle, valves, and the large coronary veins. In 1749, Jean De Senac, of France, described the ossification of the coronaries and healed infarcts in the heart. It was at this time that he also described the use of quinine in auricular fibrillation. John Baptist Morgagni in 1761 published his interesting and important observations in five books entitled "The Seats and Causes of Disease". He wrote a most accurate description of coronary sclerosis, and he himself died of the disease.

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In 1772, William Heberden, of London, published his classical description of the anginal syndrome. Heberden was an outstanding scholar and his ability to present a clear and accurate description was unsurpassed. His portrayal of the symptoms of angina pectoris stand today as a brilliant medical masterpiece of the past. Although Heberden's description of angina pectoris still stands as the most accurate and complete ever written, yet he was unaware of the fact that the symptoms resulted from heart disease, not to mention coronary disease. He also was the first to recognize exophthalmic goiter and its cardiovascular phenomena. The next half century saw little written about coronary disease. This era embraced the time when the teaching of cardiology centered around murmurs.

John Hunter, Jenner, and Parry, as contemporaries, added much to knowledge concerning the coronaries. John Hunter died in 1793 of coronary disease. Jenner associated angina with obliterative disease of coronaries. Parry wrote in 1799 a treatise, "An Inquiry into the Symptoms and Causes of Syncope Angina, Commonly Called Angina Pectoris: Illustrated By Dissections".

In 1867, Sir Thomas Lauder Brunton enriched the world with the important contribution relative to the marked relief that amyl nitrite gave to patients suffering from angina. Before this, the angina patient had received little or no help from remedial agents.

Julius Friedrich Cohenheim in 1877 described his work on embolism and thrombosis. In 1878, a physician of St. Louis and Vienna, Dr. Adam Hammer, published a report giving a fine description of coronary thrombosis and its clinical recognition. However, it was not given the attention it deserved and did not lend a profound influence on the modern concepts of this disease.

William Murrell in 1879 published his studies on the effects of nitroglycerin in angina pec-

toris. His studies showed the importance of standardization of drugs. In 1887, Augustus D. Walker published his work on a method of leading the currents from the surface of the body by means of a paired electrodes. Previous work required direct contact with the heart. His studies paved the way for clinical electrocardiography.

Wilhelm His, Jr., in 1893 accurately described the auriculoventricular bundle. In 1896, Frances Henry Williams of Boston reported his observations on the fluoroscopic examination of heart and aorta. This was one year following Roentgen's original observations.

William Einthoven in 1903 devised the string galvanometer and modern electrocardiography was well on its way. It was not until 1907 that Arthur Keith and Martin Flack demonstrated the sino-auricular node.

Sir James MacKenzie in 1908 gave us his conclusive publication concerning the identification and clarification of auricular fibrillation. MacKenzie and his brilliant student, Sir Thomas Lewis, were highly instrumental in developing the usefulness of the polygraph, and later electrocardiography. It was at this same time that the Osler influence on modern medicine was being exerted. Obrastzow and Straschesko in 1910 published a complete description of coronary thrombosis.

Although Robert Adam in 1827 came very near to the discovery of coronary thrombosis it was not until 1912 that James B. Herrick of Chicago, published his classical account of this condition in a paper entitled, "Clinical Features of Sudden Obstruction of the Coronary Arteries". The work of Herrick really popularized the importance of the recognition of coronary disease and its treatment. He also pointed out that the condition was not necessarily fatal. It is interesting to note that in 1938 Dr. Herrick presented an extremely important paper to the American College of Physicians, entitled, "On Mistaking other Diseases for Acute Coronary Thrombosis". He served well to teach the medical profession the pitfalls of attributing all chest pains to acute coronary disease.

PATHOLOGY

The most important condition involving the heart is the pathological changes which take place in the blood vessels of the heart itself, namely, the coronary arteries and veins.

In the present state of our knowledge, the coronary veins are not often the site of any serious pathologic process. It is the involvement of the coronary arteries which provides the subject of this discussion. Coronary arterial disease practically always is caused by arteriosclerosis.

We will discuss coronary insufficiency, which is usually attended by the symptom of angina pectoris, and also coronary thrombosis with myocardial infarction. Coronary insufficiency implies a lack of proper blood supply to the myocardium; this may be due to arterial disease per se, or it may be due to severe anemia, aortic diseases, severe bradycardia, persistent tachycardia, surgical shock, or blocking of the mouth of coronary vessels by syphilis.

Our discussion of coronary insufficiency will embrace only that phase in which the arteries themselves are involved in the pathological process. It must be remembered that extensive coronary disease may be present without insufficiency of blood supply. Coronary occlusion and coronary thrombosis do not necessarily mean myocardial infarction.

Myocardial infarction may occur without actual complete coronary arterial thrombosis or occlusion, and coronary occlusion may occur without myocardial infarction if the process is slow in developing and collateral circulation is adequate.

When we diagnose coronary thrombosis as an acute illness we really mean myocardial infarction. Coronary occlusion and thrombosis are not synonomous terms, as occlusion may occur without thrombosis. Our present concept then leads us to discuss the various effects of coronary arterial disease on the heart under the designation coronary heart disease. Under this we will include myocardial ischemia with angina pectoris, electrocardiographic changes due to coronary disease, acute infarction of myocardium and old scars of similar origin.

It must be pointed out that coronary sclerosis is not only found in the old, but that it may cripple and kill those in the young and middle age groups. Ordinary coronary sclerosis is part and parcel of the process of growing old. It is highly important to point out that a patient may have fairly extensive involvement in his coronaries and still the heart may remain structurally and fundamentally normal. Also that function may be impaired by limitation of blood supply but structures remain normal.

In the great majority of cases, atheroma is to blame for the pathological changes, although a fibrotic thickening or simple thickening of the intima may occur. Reaction to atheroma in youth is fibrosis; in older people it results in calcification and formation of cholesterol abscesses. The cause of this process is not known. However, faulty metabolism, local arterial strain, overwork, hypertension, infection, allergy, endocrine disturbance, heredity, and nervous reaction are some of the factors entering into this picture. It must be mentioned that trauma of various kinds may be a factor in myocardial infarction. Occasionally a congenital abnormality may be a factor in coronary difficulty.

Coronary heart disease may occur in any decade of life but naturally its incidence increases with age. The male is more often affected than

the female, and this is especially true in patients under the age of forty having coronary heart disease. It is our impression that the mentally overworked, highly organized, stout professional or business man, is more likely to suffer from coronary heart disease. Possibly the farmer is affected least of all.

It is our belief that the persistent overuse of tobacco with the constricting action of nicotine is a factor in causing coronary heart disease. The use of alcohol over many years appears to have a protective influence against the ill effects of coronary disease. Heredity seems to exert a definite influence. It is said that if the family history absolutely excludes apoplexy or coronary heart disease that the patient most likely does not have coronary heart disease. Diabetes mellitus, xanthomatosis, and hypertension, and their hereditary predisposition favors pre-senile coronary heart disease.

The effects of coronary disease on the heart are:

1. Ischemia without structural change.
2. Fatty degeneration and fibrosis.
3. Multiple infarctions.
4. Fibrosis.
5. Sudden infarction of myocardium due to occlusion of a main artery.

This occlusion of the artery occurs usually in a vessel narrowed by atherosclerosis, or from a rupture of a subintimal atherosclerotic abscess with discharge of lipoid material into lumen of vessel or by an intramural hemorrhage in a sclerotic artery, causing closure without secondary thrombosis or by an embolus.

Fibrotic changes following an infarction may cause congestive heart failure. If infarction penetrates deeply into myocardium, the subendocardial portion may be involved and arterial emboli may result. Multiple infarction, of course, makes the prognosis grave. Coincident coronary spasm outside of infarcted area is often a marked factor in prognosis.

It is well to interject here this warning—that vasoconstriction direct or reflex may play a big part in causing angina or coronary occlusion. The habit many people possess of driving themselves to the point of breaking seems to play a big part in the causation of this trouble. Repeated vacations might save many people from this serious illness.

The size and prognosis of an infarct depends on size of artery closed, rapidity of closure, extent of collateral circulation, and kind of therapy. The descending branch of the left coronary near its mouth is a common site of closure, causing infarction in the anterior wall of the left ventricle near the apex and also involving frequently the interventricular septum; hence the name "artery of sudden death". The second most frequent closure occurs in the right coronary or circumflex branch of the left, with infarction of the posterior wall of the left ventricle near the base behind the posterior cusp of the mitral valve.

Cardiac infarction results from blocking off of the blood supply from any of the main coronary arteries. The necrosis which follows sometimes extends to the pericardium and sometimes to the endocardium. Marked narrowing without occlusion may cause sudden death. The myocardium may not be infarcted but is always ischemic. The heart may or may not be enlarged by infarction. It has been shown that every patient suffering from angina pectoris without valvular disease or hypertension will show at postmortem examination evidence of at least one old complete occlusion. It has also been demonstrated that patients with long standing angina have a better chance of surviving an infarction because they probably have developed a better collateral circulation.

SYMPTOMS AND DIAGNOSIS

The symptoms arising from a closure of a coronary vessel are dependent upon several factors: The relation between the capacity of the coronary circulation and activity of the myocardium; the rapidity of change in the myocardium; the extent of the damage; the efficiency of collateral circulation; the work the heart is compelled to do; and the reaction in the nervous system of the patient. A highly nervous patient with little damage may have marked symptoms. If the work of heart is light, damage may be small, but the symptoms relatively great.

Sudden closure of a large vessel with meager collateral circulation results in severe pain, marked shock, and often in death. The symptoms of this condition most often encountered are substernal pain and dyspnea. Insufficient blood supply to the myocardium usually results in a feeling of oppression in the chest. This feeling associated with exertion should always make one suspect coronary heart disease. This feeling of pain or misery may be light, moderate, or great; high, mid, or low substernal. Extreme substernal pain or epigastric oppression continuous for hours ending in shock is due to coronary heart disease. Precordial aching may be found in other conditions, such as cardiospasm or esophageal spasm.

Many times we must diagnose coronary disease in the absence of any abnormal physical findings, without help from the electrocardiographic or X-ray findings, all of which may be normal. Anginal pain occurring after exertion or walking must be duly evaluated. This pain may come not after normal walking but after hurrying or walking following a meal. This pain may cease soon after resting. Thoracic pain after an emotional upset and not produced by exertion is most likely not of coronary origin. Thoracic pain associated with an attack of perspiration is often due to serious coronary

insufficiency. This pain if not retrosternal must be proved to be coronary by its response to exertion and subsiding on rest.

One should be skeptical of making a diagnosis of angina in a woman under fifty, because angina in women is rare in the absence of hypertension, but in men it occurs often in the presence of normal or subnormal blood pressure.

Radiation of pain may be found but is not essential to the diagnosis. Pain in the left pectoral region often projected to shoulder and arm is most often due to myalgia of a rheumatic state or to an emotional tension. These pains are most often not associated with exertion, but come after exercise or at rest, continue longer than angina, and are often associated with inclement weather or emotional status. Usually anginal pain lasts three to ten minutes. Pain lasting thirty minutes suggests an occlusion or some cause other than angina. Retrosternal pain lasting thirty minutes and associated with severe perspiration should be considered as due to an occlusion until otherwise explained.

The pain of thrombosis may be simulated by gallbladder disease, pancreatitis, gastro-intestinal condition, pulmonary embolism, or dissecting aortic aneurysm. It must be kept in mind that thrombosis may cause no pain but that dyspnea and collapse alone may be present. The pain in this condition may radiate to the arms, neck, back, jaws, or head. A failing left ventricle as the result of coronary insufficiency will cause pulmonary congestion and dyspnea. Edema or Cheyne-Stokes breathing may not be present.

Various irregularities causing palpitations may occur, as premature beats of ventricular origin, fibrillation, auricular tachycardia, paroxysmal ventricular tachycardia, or AV block. The vasomotor shock may result in prostration and collapse; this is more often found in the aged. If generalized sclerosis is present we are likely to find mental disturbances, such as faintness, dizziness, syncope, coma, or even convulsions. Vomiting, hiccough, cough, restlessness, or hemoptysis are often found. Most patients have profuse sweating and this should be properly evaluated if the patient is seen soon after an attack. Fever frequently follows the attack. If the patient is seen in an attack, pallor, profuse sweating, and prostration, should signify the seriousness of the condition. The heart may be normal in size at the time of the attack, but if the process is extensive, dilatation may later occur, the left ventricle first being involved. The pulse may soon become irregular and heart sounds at the apex are frequently weakened. As one observes the patient, gallop rhythm, protodiastolic in time, may occur, especially in left ventricle weakness.

Reduplication and gallop rhythm occur with intraventricular or auriculoventricular block. P_2 is accentuated if the left ventricle fails. Mitral bruit or aortic bruit occur if dilatation of heart or aortic dilatation ensues. Pericardial friction rub follows if infarcation is extensive enough, and is usually found on the second or third day and is transient. Bradycardia may occur if the block is marked. A falling of blood pressure is significant and the rate with which it returns may be of diagnostic importance. At the very beginning of attack the blood pressure may be elevated. X-ray is of some value, and some authors say they can map out site of infarction. The area involved in the infarct expands rather than contracts and this phenomena may be observed under the fluoroscope for some time after the coronary accident.

ELECTROCARDIOGRAM

The electrocardiogram is of great importance. If one has had one or more previous electrocardiograms on the patient, it is of much more importance. For this one reason alone we do electrocardiograms on all our patients if they are over forty years of age, regardless of physical status. It is of extreme importance that patients should have serial electrocardiograms after suspected attacks. Tracings taken the first few days may show very little. We have found the first changes to appear even eight days after attacks. The changes are found most often in Q and T waves and S-T segments. Intraventricular block and low voltage are important. Heart block is most often caused by coronary disease. When occlusion occurs, Q waves appear or become exaggerated, and T waves are deformed, becoming low, cove-shaped, inverted, disappear, or assume special shapes. High take-off of the S-T segment from the descending limb of the R wave in Lead I or III with depression of this S-T segment in the opposite lead that is Lead III or Lead I. Often the Q waves become distinct in the Q.R.S. complex in Lead I when the S-T segment is elevated in Leads I and III when S-T segment is elevated in that lead. In Lead IV, R waves tend to disappear and the S-T segment is much elevated in early stages. T waves become inverted in Q.T. types of electrocardiogram, or Q.R.S. and T stay as is or are exaggerated and the S-T segment is depressed at first in Q_3T_3 types. In a few days, the S-T segments tend to flatten out, but in I or III an inverted T wave is left. Flat or inverted T waves may persist or gradually regain normal contour in weeks or months. The Q wave may be permanent and may signify an old infarction.

Thrombosis of the descending branch of the left coronary and the associated anterior infarction is generally followed by high origin and later inversion of T wave, development of Q_1, absence of R_4 and inverted T_4. Thrombosis of the right coronary or circumflex branch of the left coronary and the consequent posterior infarction is designated usually by high origin and

later inverted T_3, development of Q_3 and relatively normal Lead IV. The Q.R.S. and T in Lead II may be normal but often T_2 is flat or inverted during the course of infarction. Lead II is of least significance diagnostically of all leads. The additional information afforded by four leads is of great importance in many cases.

If the electrocardiogram fails to help locate the position of the infarction, most often the interventricular septum is involved and the mortality rate is high.

The electrocardiogram must be considered helpful but not the entire answer to the diagnosis of coronary disease. No electrocardiographic abnormal findings does not necessarily mean no coronary disease. A normal electrocardiogram is often found on the same day that the infarction occurs. It must be remembered that changes in the electrocardiogram are found in other diseases and not only in coronary disease. Many times patients complaining of anginal attacks will show normal routine tracings, but if caught in an attack will show definite electrocardiographic changes, and in a short time after relief from pain will again have a normal curve.

Levy's test for latent coronary insufficiency may be of value. Electrocardiograms are taken under normal condition and again after patient has been breathing air containing only 10 per cent oxygen. The technique and evaluation methods are to be found in the literature. I would like to offer this note of caution. The test should not be used on patients who have had coronary occlusion within three months, or on anyone who has had congestive failure. Care should be used in testing patients over sixty years of age and the test should be stopped with the first sign of pain. A supply of 100 per cent oxygen should be on hand.

PROGNOSIS

The white blood cell count usually goes up and the sedimentation time goes down. The family is always anxious for the prognosis. Each case is an individual entity and must be judged accordingly. The outlook for life depends upon the speed and extent of damage and the reserve strength of the heart. The outlook should be considered grave when the condition is recognized clinically. Most patients survive the immediate attack. The first week is the most hazardous. Sudden death is still a danger in the second week. After three or four weeks recovery is the rule. One-half of the total number of cases survive for years, maybe for ten or more. Long survivals are frequent, but this has been recognized only recently. The prognosis is always worse if the patient is old, if shock is severe, if the blood pressure falls rapidly. Persistence of pain or recurring attacks of pain on succeeding days is a grave omen. Elevation of fever for more than a week, high white blood count for more than a week, and persistent fast sedimentation rate, point to a serious condition.

Development of gallop rhythm, congestive heart failure, tachycardia, heart block, pulsus alternans, dependent or pulmonary edema, persistent hiccough, embolic phenomena, pneumonia, hepatitis, or uremia, are of extremely serious significance. No relief from all measures usually means progression and extension of infarction.

TREATMENT

There is no specific treatment for coronary heart disease unless syphilis is an etiological factor. Where angina attacks alone are present the vasodilators are of definite help. If we are dealing with infarction then the diagnosis must be made as soon as possible. If pain is great, morphine or one of the allied drugs must be given in sufficient amount to control pain. It is well to determine first if the patient is sensitive to morphine and if so to give one of the less toxic narcotics. It can not be emphasized too emphatically how important it is to give narcotics in large enough doses to quiet the patient, relieve apprehension, and to combat shock. It is well to give atropine, grains 1/100, with morphine, as it will relieve the reflex vasoconstriction that comes with infarction. While the hypodermic of morphine and atropine are being prepared, 1/100 grain of nitroglycerine is placed under patient's tongue. After this follow with intravenous aminophylline. With this emergency measure carried out, the patient should be transported to a hospital where oxygen can be used. The hospital should be notified at once so that all will be ready when patient arrives. Oxygen often relieves dyspnea and aids in controlling pain. When oxygen is given, determine the CO_2 in the blood every 24 to 48 hours, as alkalosis may develop.

Narcotics should be repeated as needed for pain. Aminophylline is given intravenously, 7.5 grains every six hours for three or four doses. The use of aminophylline and papaverine intravenously together must be avoided because of possible serious fall of blood pressure.

Many patients are overtreated, but if given sedation, dilators, oxygen, and complete rest, one can stand by and watch for developments. If ventricular tachycardia or fibrillation ensues, quinidine may be given. We do not use it routinely after all attacks, but some men do. If congestive heart failure should develop, digitalis and diuretics are used.

The use of digitalis is restricted to those cases developing congestive failure; here the mercurial diuretics might be tried first. Digitalis should not be given on the suspicion that the patient has heart trouble. Atropine is given to alleviate

the reflex of vasoconstriction. First give 1/75 to 1/100 grains and repeat in four to eight hours.

Papaverine is given for its vasodilating effect intravenously in grain dosage. Papaverine may be used but it is still questionable as to how much good it really accomplishes.

The final outcome then depends upon the development of a good collateral circulation. If closure is gradual, the outlook is better because there exists a better chance of building up a collateral circulation. If a large area is infarcted, the outlook is more grave. Nitroglycerine is often given to anticipate pain when walking has to be done. Heparin or dicoumarol are of value as anti-coagulants when prothombin estimations can be made. Male hormones have as yet to be proven of value.

After the first crisis has been passed, complete rest, light diet, good free elimination, small amounts of whiskey, and little or no smoking, all are of value. The patient should be kept quiet in bed for about six to ten weeks, depending upon the severity of the attack and the extent of complications following infarction. If the patient is of the type that is terribly upset by constant bed rest then good judgment must be used in allowing him more activity. Visitors must be avoided for at least two weeks. Rest is of vital importance regardless of the current epidemic of getting people out of bed early for everything. In psychopathic wards where patients can not be controlled, a rupture of the heart was found in 75 per cent of coronary heart cases as contrasted to 9.5 per cent in controlled cases.

The possibility of circulatory stasis in the legs can be virtually eliminated by massaging the legs twice daily while the patient is at rest. The physiology of healing must not be overshadowed by the dramatic desire of getting the patient on the move. It is also observed that a period of rest is many times helpful in changing the philosophy of living which is necessary after a coronary accident.

I advise my patients to have a quota of three ounces of whiskey daily and to avoid smoking if possible. Levine's records show that the average age at death of smokers was 58.2 years, and of non-smokers 62.5 years.

If angina is a persistent and uncontrolled symptom paravertebral injection or nerve section may be used. Beck's pectoral muscle graft to the heart muscle inside of the pericardium has been of help. The heart has great recuperative power and if assisted may make a good recovery.

The patient's care of himself as to diet, elimination, activity both mental and physical, avoiding exposures to weather, and repeated vacations are all important aids in prolonging life. I can not refrain from again pointing out that smoking is of definite harm. It has been absolutely proven to cause constriction of the small arteries and should, therefore, be given up. Alcohol if properly used is of definite help; its overuse can be of decided harm.

The differential diagnosis in coronary disease is often very intriguing and requires careful history taking and observation to arrive at a correct conclusion. Chronic coronary difficulty is often especially difficult to diagnose. If the patient has congestive heart failure and marked irregularity one must think of thyrotoxicosis or rheumatic heart disease. A history of angina, absence of characteristic bruits found in valvular heart condition, lack of cardiac enlargement, the presence of a tortuous aorta in the X-ray, an electrocardiagraphic finding of intraventricular block, low voltage or typical T wave changes, will help to clinch the diagnosis.

Myxedema with chest pressure and electrocardiographic findings of low voltage and T wave changes are confusing. However, the inspection of the patient with low metabolic rate and high cholesterol blood findings will usually make the diagnosis. There are three other chest conditions where the differential diagnosis is of importance: Acute pericarditis, pulmonary embolism, and dissecting aortic aneurysm.

If one suspects pericarditis, the patient is instructed to hold the breath and no, or little, pain is noticed if pleuropericarditis is present, but in coronary disease this procedure will not stop the pain. The electrocardiogram will show no, or little, changes, or markedly transient changes in pericarditis. Pericarditis is more often seen in youth, but the pain, fever, leucocytosis, and friction rub can easily be misleading. In pulmonary embolism there is often a history of a surgical procedure or a recent phlebitis. The marked dyspnea, cough, spitting of blood, and the electrocardiographic findings of S wave in Lead I, inverted or lowered T wave in Lead II, a Q wave in Lead III and deeply inverted T in Lead III, and in Lead IV the T wave is inverted or flattened, all point to pulmonary embolism.

In a dissecting aortic aneurysm the pain is markedly in back and down both legs. The pain is abrupt and not gradually working up to severe pain as in coronary disease. Signs of obstruction of circulation in iliacs and femorals, with a relatively normal electrocardiogram and with a high blood pressure, usually means a dissecting aortic aneurysm.

Acute abdominal diseases are many times mistakenly diagnosed and operated upon in the presence of an acute coronary aceident. These are ruptured peptic ulcer, gall stones, and pancreatitis. The history of previous gastric distress as contrasted to anginal attacks after

exercise is helpful in making the correct diagnosis. Gastric trouble occurs more often in young and coronary disease more often in older people.

The most important thing is for the physician to think of the possibility of a coronary accident as contrasted to an acute abdominal condition, and then a physical examination done with this background will bring out the important diagnostic points. Here often the electrocardiogram will be helpful, but it must be remembered that occasionally the electrocardiogram will be affected by an acute abdominal crisis by reflex constriction of coronary vessels due to shock. Atropine given by hypodermic will relieve this and repeated electrocardiograms will be normal. This not likely to be found in coronary accident.

The possible role of trauma as a causative factor in precipitating coronary occlusion or infarction many times assumes a legal significance. This frequently comes up in workmen's compensation cases. The fact that the patient may have had coronary sclerosis before the accident or work trauma is not the point. The question to be decided is, did the accident or effort precipitate the acute infarction? The court usually favors the claimant. It is fair to insist that to be compensable the infarction should result from effort extraordinary to the job, and that signs and symptoms should follow immediately or several hours after effort.

There is a complication often seen after a coronary accident that is rarely described in the literature. We can designate this complication as a sclerodactylia—changes similar to scleroderma or abortive Reynauds. This is a trophic change, resulting from a local ischemia and change in nutrition. A definite vasoconstriction is found. It usually appears from three to twenty-four weeks after the infarction. Pain and stiffness in the hands are usually the first complaints. It then resembles arthritis. A non-pitting swelling with a smooth tight skin is found. Occasionally an erythema or cyanosis is observed. There are no nodules or effusion into the joints. The condition may persist for some time. Gradually the swelling subsides but pain and stiffness persists.

Many times the findings are uniform: bilateral, symmetrical, and the entire hand is involved. No sensory changes are found. The fingers can not be extended or flexed without pain. No crepitation is found. The overlying tissue seems to attach itself to underlying structures. There is some soft tissue atrophy. In some patients even the shoulders may change in appearance and function.

In many cases these complications may clear entirely, but often there is some residual, especially stiffness. Heat and massage help in relieving the distress from this condition. Nicotinic acid frequently will be of use. Sympathetic nerve injections will hurry the process in involuting.

The question of a surgical operation in a patient who has coronary insufficiency, or who has had a coronary accident, is frequently put to us. If the patient does not have congestive heart failure, and has not had an acute coronary accident within six months, they may be operated upon. Spinal anesthesia is not desirable in either instance because of the hazard of falling blood pressure. Spinal anesthesia in older people is of potential danger. If used in such persons, the blood pressure must be maintained and a generous amount of oxygen used during operation. Shock, however, produced, may lead in elderly patients, especially those showing evidence of coronary sclerosis to not only a single but often to multiple, infarctions. Lowering of blood pressure, tachycardia and dehydration must be prevented. In young people frequently a syndrome simulating an infarction may be found which, when carefully analyzed, will be found due to a rheumatic infection. Here the electrocardiogram may show T changes with both anterior and posterior localization, and occasional R-T changes and absence of Q.R.S. changes.

CONCLUSIONS

In conclusion these points are stressed:

1. Coronary disease is becoming more common.

2. The early diagnosis of an acute coronary accident is of great importance.

3. Do not overtreat the patient with coronary disease.

4. The importance of treating the vasoconstriction reflex in coronary accident should be emphasized.

5. Large doses of narcotics are necessary for the control of pain.

6. Rest is a primary requirement and should be continued for a period long enough for a good collateral circulation to develop.

7. People can live and do fruitful work after a coronary accident.

8. The diagnosis of coronary insufficiency without myocardial infarction rests, as it did in the days of Heberden, upon the proper evaluation of the patient's story.

9. Serial electrocardiograms are often of the greatest help in establishing a diagnosis of coronary disease, but in occasional instances entirely negative electrocardiographic findings may be misleading.

10. The diagnosis of coronary disease should be made only after the most careful examination and history taking in order to avoid unnecessary cardiac invalidism.

Diagnosis of Non-Traumatic Intracranial Lesions

W. JAMES GARDNER, M. D.

IT has been suggested that I furnish a thumbnail sketch of the clinical picture of some of the more common intracranial lesions which may enable my non-neurological colleagues to recognize more readily some of these conditions when they are confronted with them. I will confine my remarks to a consideration of intracranial tumors, brain abscess, trigeminal neuralgia, Ménière's disease, and spontaneous subarachnoid hemorrhage.

In the diagnosis of intracranial lesions as in most other fields of medicine, the primary requisite is an adequate history of the disease. This is of more value in arriving at a neurological diagnosis than are the objective signs. If the patient presents himself with a hemiplegia one can tell at a glance that he has a lesion in the contralateral cerebral hemisphere, but in order to determine whether the lesion is a tumor, a stroke, encephalitis, multiple sclerosis, brain abscess, or brain wound, one must obtain a history of the development of the symptoms.

What symptoms should lead the physician to suspect that the patient has an intracranial lesion? Headache, although it may be produced by a number of extracranial factors and many functional nervous disorders, still is the most common symptom of organic intracranial disease. The headache may be localized or generalized. It is usually intermittent and seldom present for many years as are familial or functional headaches.

One symptom which invariably points to an intracranial lesion is convulsions. The only exceptions to this are the rare instances of extraneous poisons, uremia, and occasional hypoglycemic states. Only the brain can initiate a convulsion. From the detailed description of the convulsion it is sometimes possible to localize accurately the lesion which is causing it.

If the patient has a hemiplegia, it is pretty safe to assume that the lesion is in the brain, whereas if the paralysis affects both legs it is almost certain to be in the spinal cord. If the patient has an homonomous hemianopsia, that is, a blindness in the right or left field of vision of each eye, the lesion is certainly in the brain. Since the brain is the abode of consciousness and the seat of the intellect, a disturbance of either of these functions surely indicates a cerebral condition, although the symptoms may be due to a physiological rather than an anatomical disturbance. In the absence of objective findings, there is no certain method of proving that cerebral symptoms are not due to hysteria or psychoneurosis, but it is well to remember that a feeling of pressure at the top of the head is common in psychoneurosis and almost never seen in organic intracranial disease.

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INTRACRANIAL TUMORS

What symptoms should make one think of the possibility of brain tumor? The most common clinical evidence of tumor of the brain is a history indicating a steadily progressing lesion of the brain. A hemiplegia may be due to a brain tumor but is much more commonly due to a stroke. But if a person presents himself with a hemiplegia which began with a slight awkwardness or difficulty in using one extremity and then progressed steadily over a period of weeks or months, one should think, first of all, of the possibility of a tumor of the brain. A steady march of cerebral symptoms, progressing over a period of time, with new signs being added but none disappearing, is typical of this condition. If the patient is in the arteriosclerotic age group and the cerebral signs appear suddenly, the odds naturally favor cerebral vascular disease. If the patient is a young woman and the neurological symptoms appear and then disappear, multiple sclerosis must be considered. The patient with multiple sclerosis seldom has pain and does not feel sick. If the cerebral signs are accompanied by fever, one must consider encephalitis, meningitis, and brain abscess. Mental symptoms commonly encountered in intracranial tumor are impairment of memory, changes in personality, and a progressive blunting of the intellect. Actual psychotic states are very rare.

About 75 per cent of patients with brain tumor, by the time their symptoms impel them to seek medical help, have developed increased intracranial pressure. These symptoms are headache, vomiting, which is frequently projectile

and sometimes unassociated with nausea, and later failing of the vision. In children, vomiting is more common than in adults and may not be accompanied by headache. The exact physiological mechanism of the vomiting induced by increased intracranial pressure has not been adequately explained. The loss of visual acuity when due to an intracranial tumor is invariably accompanied by either edema or by atrophy of the optic discs. An intracranial tumor can not reduce visual acuity if the optic nerve is normal. It may cause a homonomous field defect in the presence of a normal appearing optic nerve but not a loss of acuity. The visual loss in brain tumors progresses slowly.

The patient who presents himself with a rapid failure of vision over a period of a few days, with papilledema but with no headache, has optic neuritis and not brain tumor. Aside from the evidences of increased intracranial pressure, one should be suspicious of the possibility of a brain tumor in any patient who exhibits a progressive blunting of the intellect or a progressive diminution of cerebral function of any type. Brain tumor should be considered as a first possibility in the case of any person over 30 who develops convulsions, and particularly is this the case if the convulsions affect one side of the body, that is, if they are Jacksonian in character and are followed by a temporary paresis of the limb in which they originate. The rapidity of the progression of the symptoms is usually, but not always, an indication of the rapidity of the growth of the tumor and therefore an indication of its malignancy.

A study of the visual fields of patients with intracranial tumor is extremely important in determining the location of the growth. A right homonomous hemianopsia or loss of vision in the right half of each visual field means without exception that the lesion is in the left temporal or occipital lobe of the brain, and vice versa. The presence of a bitemporal hemianopsia or loss of the temporal half of each field of vision is even more informing. A bitemporal hemianopsia can be produced only by a lesion that presses on the optic chiasm, and the lesion is always a surgical one. Bitemporal hemianopsia is never produced by a stroke, encephalitis, or other nonsurgical conditions as may be the case with a homonymous field defect.

Now, let us proceed to a consideration of the various types of tumors of the brain. The common types in order of their frequency are: the gliomas, the meningiomas, tumors of the acoustic nerve, pituitary tumors, and metastatic carcinomas. Strictly speaking, the glioma is the only true brain tumor. It arises from the glia or interstitial tissue of the brain which constitutes the supporting framework for the neurones or functioning nervous tissue. The meningiomas arise from the membranes covering the brain. The pituitary tumor arises from the epithelial cells of the anterior lobe of the pituitary gland. The acoustic tumor arises from the sheath of the eighth cranial nerve.

GLIOMA OF THE CEREBRAL HEMISPHERES

In adult life, gliomas of the cerebral hemispheres are encountered more frequently than any other single type of tumor. These vary in malignancy from the rapidly growing glioblastoma to the slow growing benign oligoglioma. A fairly typical case history of the former type of tumor is as follows: A healthy, active man of 50 begins to complain of headache. He ignores it for a few weeks, but the headache increases in frequency and severity so that he stays home from work. It is then noted by the family that his memory is impaired and that he is occasionally mildly confused. The symptoms daily increase in severity and new ones appear. There is numbness or weakness of one side of the body and blurring of vision. The patient seeks medical help about two months after the appearance of the initial symptoms. At this time he is found to be lethargic and confused, complains of headache. There is a weakness of one side of the body, with exaggeration of the tendon reflexes. On ophthalmoscopic examination there is swelling of the optic discs with some retinal hemorrhages. This clinical picture favors a rapidly growing glioma, probably a glioblastoma. This is the type of neoplasm which has gained for brain tumors a most unenviable reputation. It represents about 12 per cent of all intracranial tumors.

The oligoglioma is at the other end of the scale as far as malignancy is concerned. This tumor may cause symptoms for ten years or more before the diagnosis becomes apparent. The initial symptom is most commonly a convulsion, usually Jacksonian in character. The convulsions recur at first at long intervals, perhaps years, but steadily increase in frequency and are accompanied by gradually increasing weakness and spasticity of the extremities affected by the convulsion. Between the glioblastoma on the one hand and the oligoglioma on the other, there are many types of gliomas of varying degrees of malignancy and less clear cut clinical syndromes.

THE MENINGIOMA

The meningioma is a benign, encapsulated growth originating in the meninges and compressing but not invading the brain. It occurs most commonly in the fourth and fifth decades of life and is rare prior to the third. Because it does not invade the brain it lends itself more frequently to a permanent cure by removal than does the glioma. Although a preoperative diag-

nosis of meningioma is not always possible, nevertheless, there are certain findings in the majority of cases that make the diagnosis likely. These tumors are slow growing and the symptoms date back many months or even years. The initial symptom in about one-third of the cases is a convulsion. There is sometimes a swelling of the scalp over the site of the tumor and an X-ray examination of the skull will give localizing evidence in at least one-fourth of the cases. However, the point upon which the differential diagnosis most frequently hinges is the occurrence of a slowly growing tumor in a location known to be a favorite site of the mengioma.

ACOUSTIC TUMOR

In a patient with an acoustic tumor, a careful chronological history will usually establish the diagnosis. As these tumors grow on the sheath of the eighth cranial nerve, the initial symptom, as might be expected, is tinnitus accompanied by or followed shortly by increasing deafness. Sometimes there is a brief period of mild vertigo at the onset due to irritation of the vestibular fibers of the eighth nerve. As these fibers are paralyzed by the tumor much earlier than are the auditory fibers, this vertigo, if present early, may soon subside. There then follows a progressive impairment of hearing in the affected ear which becomes complete in a period of months or years. The next symptom is usually a mild unsteadiness of gait which progresses slowly to a marked cerebellar ataxia. During this time, headache and cranial nerve signs make their appearance. The headache is more commonly suboccipital and may be confined to the side of the tumor. As the headache becomes more severe, it is accompanied by forceful vomiting, diplopia, failing vision, and staggering toward the affected side.

Examination at an early stage in this disease will disclose merely unilateral nerve deafness and lack of response to the labyrinthine tests of Barany on the affected side. Later on, there will appear anesthesia of the cornea, coarse nystagmus, especially on looking toward the side of the tumor, ataxia on the affected side, slight facial weakness, internal squint, choked discs, and unilateral suboccipital tenderness. Roentgen examination frequently will disclose some erosion of the posterior surface of the petrous bone.

PITUITARY TUMOR

Tumors of the pituitary gland occur most commonly between the ages of 20 and 40. In the woman, the first evidence of a pituitary tumor is amenorrhea. In the male, the first symptom is apt to be loss of sexual potency. But the symptom which brings the patient to the physician is loss of vision which is due to primary optic atrophy and not to papilledema. Clinically, the symptoms of pituitary tumor may be divided into the endocrine signs which appear early, and the pressure signs such as headache and failing of vision which appear later. There are two chief varieties of pituitary tumors, the chromophobe variety with the accompanying hypopituitary signs such as diminution of libido, moderate obesity, amenorrhea in the female, diminution in the hair on the body and face of the male. There is usually a subnormal metabolic rate, and an increased glucose tolerance curve. In the acidophilic variety, the patient presents the striking picture of acromegaly. The features are large and coarse, the hands and feet are thick, there is spacing of the teeth. With this type of lesion there is frequently increased metabolism, elevated blood pressure, and diabetes mellitus. The characteristic finding in the visual field is a bitemporal hemianopsia. It is important to make an X-ray of the skull in any woman with unexplained amenorrhea. If it is due to pituitary tumor, the distention of the sella will be unmistakable.

METASTATIC INTRACRANIAL TUMORS

About 5 per cent of intracranial tumors are metastatic and the most common origin is carcinoma of the bronchus. The original lesion in the lung may be asymptomatic. Every person of middle age with symptoms of a rapidly growing intracranial tumor should have an X-ray of the chest. If this discloses a tumor of the lung, it is safe to assume that the intracranial lesion is metastatic. Metastatic tumors of the brain are apt to be multiple and the neurological signs, therefore, vague and conflicting. Headache is invariably severe and the symptoms rapidly progressive.

BRAIN TUMORS OF CHILDHOOD

Usually, the symptoms of increased intracranial pressure in children occur before there are any focal signs to suggest the location of the lesion. Recurring attacks of headache and vomiting without nausea are the rule. These occur at intervals of days or weeks with completely symptom-free intervals. Recurring bouts of sudden vomiting without headache are not uncommon. The physician's attention, therefore, may be centered on the gastro-intestinal tract for months or until serious visual disturbance points the way to the correct diagnosis. The visual disturbance may be diplopia due to sixth nerve paresis from the increased intracranial pressure, or this paresis may proceed to an obvious internal squint before the child complains of it. Failing vision also may reach the point where it is evident to the parents before the child is aware of it. The important thing to remember is to make a fundus examination in any child who is having attacks of headache or vomiting. Another simple, though later sign of increased intracranial pressure in children, is the cracked pot sound on percussion of the skull (Macewen's

sign). This is due to the separation of the cranial sutures which are not firmly united in children.

The most common tumor in childhood is the glioma of the cerebellum. These are almost always located in the midline between the two cerebellar lobes and are of two varieties. The cystic astrocytoma is the most benign of the gliomas and yields brilliantly to surgery. The other type, known as medulloblastoma, is composed of highly undifferentiated cells. It can not be excised completely but responds better to roentgenotherapy than any other brain tumor. These tumors, because of their midline position, soon obstruct the flow of cerebrospinal fluid from the ventricles and thus cause an obstructive hydrocephalus. Localizing signs are frequently lacking or at most may consist of an instability of gait. Nystagmus may be absent in these midline tumors.

Another tumor encountered in childhood and adolescence is the tumor of the hypophyseal stalk usually referred to as the craniopharyngioma or Rathke's pouch cyst. This tumor arises just above or within the sella turcica from embryonal cell rests left by the outpouching from the primitive nasopharynx which grew to form the anterior lobe of the pituitary gland. Because of pressure on this gland, these tumors usually produce signs of pituitary hypofunction. These children, therefore, are apt to be chubby and dwarfed and the signs of puberty are lacking. In spite of their location in close proximity to the optic nerves and chiasm and because of their cystic nature and slow growth, the resulting loss of vision comes on late and progresses gradually. When the cyst has attained sufficient size to compress the third ventricle and thus produce an obstructive hydrocephalus, symptoms of increased intracranial pressure supervene with rapid loss of the remaining vision.

Gliomas of the cerebral hemispheres occur in children but they do not produce a syndrome as characteristic as those described above. The meningiomas and neurofibromas rarely occur before the age of maturity.

BRAIN ABSCESS

Cerebral abscesses are due most frequently to mastoiditis, secondly, to sinusitis, thirdly, to metastasis from a pulmonary infection, or an infection in some other portion of the body. Abscesses of the brain, secondary to otitic or sinus infection, occur by direct extension of the infection through the membranes of the brain, or by an extending thrombophlebitis. These abscesses are usually single. Metastatic abscesses, on the other hand, are usually multiple. Brain abscesses may occur as a result of an acute or chronic mastoiditis or sinusitis. The cerebral invasion, as a rule, is ushered in by a chill, headache, and sometimes by a convulsion. There are frequently pronounced meningial signs at the onset and the cell count of the spinal fluid may be quite high. With treatment for the meningitis, the patient rapidly improves, and particularly in these days with the use of penicillin and sulfonamides, there may occur a free interval in which the patient is almost well. Within a few weeks, however, progressive signs of an expanding intracranial lesion occur. The patient develops increasing headaches and somnolence. Since the abscess is well encapsulated by this time, the temperature may be normal or even subnormal and the white cell count of the blood may not be increased. In some cases, the cell count of the spinal fluid may be normal, but as a rule there is mild pleocytosis. It is well to remember that the patient with abscess of the brain is dull, apathetic, and irritable. He is never bright and alert.

Abscesses of the brain are more readily localized than are tumors of the brain. Since the majority of abscesses of the brain, in civil practice, occur as a result of infection in the mastoid process or sinus, one merely has to look for signs implicating the portion of the brain adjacent to the infection. If the abscess is secondary to mastoiditis, it is in the temporal lobe or cerebellar lobe on the same side. If the abscess is in the temporal lobe, the patient will have a homonomous hemianopsia. This is almost without exception, and this neurological defect is very readily demonstrated, even in the patient who is quite lethargic. It may be determined by simply having the patient look at the examiner's nose while the examiner waves his hands on either side and asks the patient how many hands he sees. If the patient only sees one hand, then he has an homonomous hemianopsia on the side on which he fails to see the hand. This simple test can be carried out even in the very ill patient where a study of the perimetric fields would be entirely impossible. An abscess of otitic origin on the left side is very apt to cause aphasia, but in the average case the abscess does not extend high enough to involve the motor area of the brain and thus cause hemiplegia. If the abscess is in the cerebellum, there will be no hemianopsia. There will be ataxia, more pronounced on the side of the lesion, and nystagmus on lateral gaze. The patient's scalp is sensitive over the site of a brain abscess. Brain abscesses secondary to sinus infection are nearly always in the frontal lobes of the brain, and usually on the side of the most pronounced infection. They are apt to be accompanied by osteomyelitis of the frontal bone producing tenderness and edema of the forehead. Localizing neurological signs are usually absent, but the patient is apt to be quite somnolent.

TRIGEMINAL NEURALGIA

Now, let us proceed to a consideration of trigeminal neuralgia. Trigeminal neuralgia or tic

douloureux is a lancinating paroxysmal pain in the distribution of one or more of the branches of the trigeminal nerve. Each paroxysm lasts only a few seconds and is frequently likened to an electric shock. It is a disease of middle and later life but occasionally appears in young subjects. In the beginning, the pain is confined to one branch of the nerve, most frequently the infra-orbital or mandibular, but with the passage of time it tends to spread to other branches. The supra-orbital branch is very seldom involved primarily. The disease affects both sexes about equally and in approximately 2 per cent of the cases the pain is bilateral.

The cause of trigeminal neuralgia is not known. By the patient, however, the teeth are always looked upon with suspicion because the pain resembles that produced when a dentist's drill touches a sensitive pulp and because it is frequently incited by chewing. Despite this, however, it can be said with authority, that no dental condition, however neglected and aggravated, can cause tic douloureux. Within a few months of the onset, these sufferers have several or perhaps all of their teeth removed, usually at their own insistence and always to no avail.

The intervals between paroxysms are usually entirely pain-free but the patient lives in constant dread of the next attack. He learns that certain actions, such as talking, eating, drinking, blowing the nose, shaving, and washing the face, are especially likely to bring on a paroxysm. When certain small areas, called trigger zones, are touched, a paroxysm is apt to be incited. These trigger zones may be anywhere within the area of the trigeminal nerve but are especially frequent on the upper lip, near the ala of the nose. A light touch is more apt to induce a paroxysm than is heavy pressure. At times there are latent intervals during which no form of stimulus will incite an attack.

Spontaneous remissions are a characteristic of trigeminal neuralgia. They occur more frequently and last for a longer time in the early stages of the disease. The spontaneous remissions may lead to misconceptions regarding the efficacy of various attempts at treatment. Not infrequently, the patient will report that the removal of a tooth, a change in climate, or the use of some new medicine "cured the pain for six months" when, as a matter of fact, the "cure" was a spontaneous remission.

In making a diagnosis of trigeminal neuralgia, the doctor must depend largely on the patient's description of the pain. Usually, however, there are secondary outward signs which should be sought out. In many cases, a voluntary "splinting" of the facial muscles is caused by the patient's endeavor to ward off the attacks. The painful side of the face is not washed as thoroughly as the opposite side so that sebaceous material collects about the ala of the nose. During severe attacks, cleansing of the mouth is avoided, debris accumulates on the teeth, the tongue is coated, and the breath foul. The reaction to the paroxysm differs with the patient but usually follows a set pattern in each case. One patient may suddenly become immobile, "freeze" so to speak, with the onset of each pain; another may grimace; another may grab or rub the face firmly. In testing the sensation in patients with tic one finds a definite over-response to painful stimuli. These patients are apt to withdraw quite vigorously from a pinprick even though it is not the painful area which is being tested.

There is undoubtedly a "tic constitution". Patients so afflicted are more or less temperamentally alike. They are apprehensive and disposed to worry about minor matters. They are nauseated by morphine and never become addicted to its use. There is a definite tendency for these patients to seek out fellow sufferers, so that the average patient knows of as many cases as the average physician will encounter in a lifetime of practice. Despite the frequent presence of arteriosclerosis and hypertension, longevity seems to be the rule. These patients do not like to go to bed and are usually up and around even when seriously debilitated by frequent paroxysms and the attendant starvation.

MÉNIÈRE'S DISEASE

Vestibular vertigo is a relatively common condition which comes on usually in middle age, not often in young people. It consists of sudden severe attacks of an intense feeling of rotation. The patient feels that he is spinning or that the room is spinning about him. He must grab something quickly for support or he may fall. He becomes pale and breaks out into profuse perspiration and he may vomit. The attack may clear in a few minutes or may last for hours. During a severe attack, the patient is as helpless as if he were in the throes of a convulsion. An attack may be precipitated by movement. Because of fear of falling the patient usually lies down. The contact of his body with the bed offers him reassurance through his tactile impressions that he is not falling although his vestibular sensations suggest that he is spinning through space. In the intervals between the attacks, the patient is free of symptoms except perhaps for unilateral tinnitus and deafness. If auditory symptoms are present in the free interval they are apt to be aggravated during the attacks. In this condition as in tic douloureux, one is largely dependent upon the patient's description of his attacks in making the diagnosis. But, if the patient is seen in an attack, nystagmus can be demonstrated. In an occasional case of vestibular vertigo the condition may be due to closure of a eustachian tube. In the very rare case an intra-

cranial tumor may be causing pressure on the eighth nerve. In the majority of instances, however, no cause can be demonstrated. The progress of the symptoms indicates a slow, progressive degeneration of both the auditory and vestibular portions of the eighth nerve.

SPONTANEOUS SUBARACHNOID HEMORRHAGE

Spontaneous subarachnoid hemorrhage in most instances is due to rupture of a congenital aneurysm on the circle of Willis in a person whose vascular tree is otherwise free of disease. Aneurysms are more common on the cerebral vessels than on any other portion of the vascular tree and they most commonly announce their presence by a rupture resulting in a spontaneous subarachnoid hemorrhage. This condition is commonly encountered between the ages of 20 and 50. The diagnosis is not difficult. The patient, usually a young adult, apparently in the best of health, is suddenly seized with excruciating headache, which may be frontal or occipital. It comes on so suddenly that some of the patients have said they felt as though they "had been hit on the head with a club". The patient may fall to the floor unconscious, occasionally he has a convulsion. He usually vomits. There is seldom paralysis. The headache continues without intermission. It is most severe at the onset, then there occurs a slow gradual improvement over a period of two or three weeks. Recurrences of bleeding are the rule. On examination the patient is found to have low grade fever. There is marked nuchal rigidity and Kernig's sign is always present. Occasionally there are hemorrhages of the retina. The spinal fluid contains blood, and the pressure is increased. There is a growing feeling in favor of surgical treatment in this condition. This is due to the fact that it occurs predominantly in young people without other evidence of vascular disease, and the mortality with conservative treatment is quite high. In reported series it varies from 28 to 50 per cent. Intracranial aneurysms occasionally announce their presence by symptoms other than those attributable to rupture. These symptoms are unilateral headache, and double vision. Intracranial aneurysms may at times attain such size as to be mistaken clinically for tumor in the brain.

SUMMARY

For the diagnosis of intracranial lesions the neurologist has at his command a number of valuable tests such as spinal puncture, X-ray of the skull, perimetric studies, Barany studies, encephalography, ventriculography, and electroencephalography. But the most important aids to diagnosis will always be an adequate history, a careful evaluation of the signs, and a knowledge of the behavior of intracranial lesions.

KEEPING UP WITH MEDICINE

OCCULAR headache is most often orbital, supraorbital, or frontal. It is usually dull, constant, and sometimes throbbing. It is often relatively mild.

* * *

BENADRYL promises to be a definite addition of limited worth to our equipment to manage allergic manifestations. Allergic patients will still demand careful study and systematic control.

* * *

LABORATORY methods for the detection of specific vitamin deficiency are still giving considerable trouble.

* * *

WHERE it can be shown that the indication is for the stimulation of the sympathetic nervous system rather than of the parasympathetic, testosterone is the hormone of choice.

* * *

FAVORABLE results have been observed following the inhalation of penicillin aerosol in selected cases of bronchopulmonary disease including bronchitis, bronchiectasis, lung abscess, and sinusitis.

* * *

APPARENTLY the agranulocytosis which develops after sulfonamides is not due to an induced hypersensitivity but is rather a toxic reaction, whereas pyramidion, thiouracil, and certain other drugs do produce a type of hypersensitivity with agranulocytosis as the reaction.

* * *

THE replacement of a large part of the starch filler in baking powder does seem to interfere with the leavening action of the baking powder. We may therefore expect another supplemental feeding of lime in our biscuits.

* * *

IT is thought that the sex hormones have a direct vasodilating action.

* * *

ONE of the most interesting of the newer applications of the reducing properties of vitamin C is in detoxifying certain drugs.

* * *

CONTACT dermatitis requires the determination of the offending agent and its subsequent removal but this is not always practical. Where it is not, occlusive dressings affords a rapid efficient method of contact avoidance. Crude tar or boric acid ointments covered with bandage serve admirably.

* * *

PRIMARY bronchiogenic carcinoma is one of the most frequent carcinomas in the body, representing some 15 per cent of all carcinomas. Thirty years ago before cigarette smoking became so common we gained national distinction by assembling some four cases.—J.F.

War Advances Anesthesia

K. C. McCARTHY, M. D.

WAR is the greatest calamity that befalls mankind. In its wake ride the apocalyptic horsemen of death, famine, disease, and destruction. It is tragically wasteful of life, time, and money. However, in the fierce concentration on victory of the best minds of all nations, important scientific discoveries are made, and medical progress results from the opportunities to test on a vast scale, theories of therapy that otherwise would require years of patient observation. It is true, therefore, that most wars have been associated with a remarkable increase in medical knowledge, and an attempt will be made to enumerate some advances made in anesthesia as a result of the accumulated experience of the last five years.

The Author

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PROFESSIONAL STATUS

The war has markedly advanced the professional status of the anesthetist. As a result of the fine example set by a small group of well-trained men who volunteered early, and due to the influence of the high type of consultant appointed for the various theatres, the anesthetist in the army hospital was placed in a position that he enjoys in few civilian institutions.

In most general hospitals he was equal in importance, if not in grade, with the chiefs of such major sections as general or orthopedic surgery. He was the key man of the surgical service, for "in addition to his other duties", it was his responsibility to organize and train the operating room staff of anesthetists, and surgical nurses and technicians. He was responsible for the aseptic technic of the operating room and through the central service department, of the whole hospital. He arranged the surgical schedule; in this phase alone the productivity of the surgical service was directly proportional to the efficiency of the anesthetist. He frequently acted as supply and procurement officer for the surgical service. He was in charge of blood transfusions, the procurement and bleeding of donors, and supervision of plasma and other intravenous therapy; this assignment alone was of critical importance on a busy service. He supervised oxygen and other inhalation therapy. His training in regional anesthesia made him a valuable consultant for diagnostic and therapeutic nerve blocks. The treatment of such immediate postoperative complications as shock and atelectasis was his responsibility. In brief, he was the sparkplug and trouble shooter for the whole surgical service, and as most military hospitals were predominantly surgical, the anesthesia section could make or break the hospital.

In the field the anesthetists assigned to Field Hospitals made an amazing record in the handling of non-transportable casualties. Due to careful, skillful anesthesia and adequate schock therapy, these cases were treated with a mortality that, judging from all previous experience, was actually miraculous.

The surgeons returning to civilian practice, who have experienced the advantage of expert judgment and cooperation of medical anesthetists, will not be satisfied with inferior service. Their requirements must be met; the supply is still inadequate. The brilliant record set by military anesthesia is a challenge to all of us to provide a better and more complete service; it is a golden opportunity to advance the status of professional anesthesia.

EDUCATIONAL

Early in 1942, the Surgeon General of the Army asked the American Board of Anesthesiology for the names of 883 qualified anesthetists; which number, it was estimated, would be necessary to supply the Army alone. At that time there were only 230 diplomates of all ages and sexes, many of them essential for the educational programs of their hospitals or medical schools. The American Society of Anesthetists was then contacted; they could supply the names of slightly over 900 active members, many disqualified by age, sex, or physical disability, and not all competent to provide the desired service.[2]

Presented at the Annual Meeting of Ohio Society of Anesthetists held in conjunction with the Centennial Anniversary Meeting of the Ohio State Medical Association, at Columbus, May 7-9, 1946.

It was obvious that an active educational program must be instituted immediately if the Army was to have any kind of adequate anesthesia. Accordingly, courses of instruction of twelve weeks' duration were set up in five civilian institutions where adequate facilities existed. Later, as departments under well-qualified men were established, this training was taken over almost entirely by Army General Hospitals in this country and the various overseas theatres. As a result of this program, 564 medical officers were trained in this country alone, and an additional large number in overseas installations. It was possible only to teach fundamentals in such a short time, but an attempt was made to stress methods and technics required for casualty anesthesia. Nitrous oxide and ether, pentothal, endotracheal and regional block technics and resuscitation were emphasized.

The training afforded by the Army was obviously inadequate; no attempt was made to turn out finished anesthetists, but the brilliant record made by anesthesia groups in combat areas reflects the soundness of the foundation established and the ability, enthusiasm, and resourcefulness of the individual officers. Many of these physicians had no previous experience in anesthesia; most through this training have developed a keen interest in the specialty, and many will wish to continue their training to become well-qualified anesthesiologists. Already their interest has resulted in a demand for residencies and other postgraduate training that far exceeds the supply, even though facilities have been doubled by prewar criteria. This educational program of the Army, therefore, has resulted in a group of young enthusiastic men, who, if encouraged to continue their training by academic instruction or preceptorships, will form the backbone of the profession in the future and will go a long way toward relieving the scarcity of capable men that is hindering the advance of professional anesthesia.

To be fair, it must be said that some of these officers had no interest in anesthesia, but were assigned to these courses because of the pressing need. They will not continue as anesthestists but every one is bound to have a better appreciation of anesthesia, and on that account will be a better physician, no matter what field he may choose.

The older anesthetist, who considered himself well-trained, has been broadened by his military experience. He was shaken out of that rut into which many of us seem to sink. By practicing under entirely different circumstances, with a different type of patient, he was forced to modify his technic and learn new methods. By contact with the best medical minds from all parts of this country, and of foreign countries too, he could not avoid assimilating new ideas. Returning to civilian life he is bound to be a better anesthetist and a better physician.

The accumulated experience of the past five years, covering as it does hundreds of thousands of anesthesias with many different agents to patients in all stages of physical deterioration, has crystallized our thinking and destroyed a number of pet theories about different drugs and methods.

NITROUS OXIDE

The inflammable gases, ethylene and cyclopropane, were neither supplied nor permitted in Army installations. Our complaints were loud, frequent, bitter, and quite unsuccessful, and it was freely predicted that without cyclopropane a good anesthesia service was impossible. Actually, its absence was scarcely noticed. It was learned, or relearned if we had forgotten, in our enthusiasm for the newer gases, that nitrous oxide is an agent that has a wide field of usefulness. It is superior to cyclopropane in many respects for it is non-explosive and produces no cardiac disturbances. Induction and recovery is more rapid and more pleasant. If supplemented with sodium pentothal or minimal amounts of ether, an efficient anesthesia without hypoxia can be obtained that is applicable in many situations where cyclopropane might seem to be first choice. War experience is bringing about a revival of this valuable agent.

SODIUM PENTOTHAL

At the outbreak of hostilities it seemed as if pentothal, on account of its convenience and portability, would be the ideal military anesthetic, and it was enthusiastically used for a wide variety of operations by many men who were not familiar with its limitations and dangers. The results were disastrous. The mortality was 1 in 450 (.22 per cent) which was six times higher than that of all other agents combined. At Pearl Harbor where it was given freely to those shocked and burned, severe respiratory depression, frequently fatal, was common after minimal doses.

The situation became so alarming that the Surgeon General considered prohibiting its use, but after study of the fatalities the following observations were made: As pentothal depresses the response of the respiratory center to carbon dioxide, respiratory action is maintained by the anoxic stimulus of the carotid sinus-aortic mechanism. Anoxemia caused by shock or respiratory obstruction therefore will produce a respiratory stimulation, which being interpreted as light anesthesia may result in a fatal overdose being given. Anoxemia must be avoided by the administration of oxygen. Pentothal increases vagal reflexes which may lead to severe laryngo or bronchospasm, or cardiac inhibition. These reflexes should always be depressed by adequate doses of atropine. As pentothal does

not depress the carotid sinus-aortic reflexes, operative trauma in the neck may set up powerful respiratory and cardiac inhibition by stimulation of this mechanism. It should not be used therefore for operations in the neighborhood of the carotid sinus.

"Pentothal should be avoided when the operative position or procedure may interfere with the airway or make artificial respiration difficult as in operations in the face down position, in operations on maxillo-facial injuries or other injuries involving the airways. In intracranial surgery, pentothal is not a wise choice because such operations are usually long and are associated with great blood loss. Moreover, anoxia due to unexpected respiratory depression produces immediate swelling of the brain and may make an intracranial procedure difficult or impossible. Patients with severe burns tolerate pentothal poorly."[3]

Pentothal should be limited to procedures which will not consume more than thirty minutes in which good relaxation is not essential, and to patients in good condition. Proper atropinization, routine oxygen administration, and careful observation of the airway, pulse, and blood pressure at all times are essential for safety.

As a result of these restrictions governing the use of pentothal, in the next year the mortality dropped to 1 in 5,500 (.018 per cent), and this in spite of the fact that its use had increased from 53 per cent to 62 per cent of cases in the forward hospitals, and from 28 per cent to 48 per cent in rear areas. This large scale demonstration of the scope and limitations of pentothal anesthesia is one of the most important contributions of the war to anesthesia.

Military experience has also demonstrated that the theoretical incompatibility of pentothal and sulfonamides does not exist; that the solution may be kept a week or ten days without deterioration; and that a combination of pentothal and nitrous oxide retains most of the advantages, and avoids most of the dangers of these agents used alone. Its administration was facilitated by many ingenious gadgets improvised by field anesthetists.

ETHER

Inhalation anesthesia with ether was shown to be a safe, in fact the preferable, anesthetic for those in shock, provided ample oxygen was available and the anesthesia was not too deep or prolonged. This was usually accomplished most easily by adding ether to a light nitrous oxide-oxygen mixture. This technic made ether practical in the tropics where it traditionally was contraindicated. The ingenuity of field anesthetists in improving closed inhalers when conventional apparatus was not available, overcame most of the disadvantages associated with high environmental temperatures. Of course, no war was necessary to demonstrate the simplicity and practibility of open ether.

LOCAL ANESTHETIC AGENTS

As a result of numerous reactions associated with the use of the more toxic agents, a number of principles were established. Infiltration anesthesia was limited to ¼ or ½ per cent procaine solution; for nerve block, 1 or 2 per cent solutions might be used, but the total dose was not to exceed 2.0 grams. Cocaine was to be used for topical anesthesia in nose and throat work only. The strength was not to exceed 20 per cent; the dose was limited to 0.1 gram. Butyn, in concentrations not to exceed 2 per cent, was limited to surface anesthesia in eye surgery. Pontocaine (2 per cent) was permitted for topical anesthesia, but no anesthetic was to be injected into the inflammed, traumatised, or obstructed urethra.

Procaine was recommended as the spinal anesthetic agent of choice in doses up to 150 mgm. In installations where an experienced anesthetist was available, pontocaine and metycaine might be used. Apparently even expert supervision was inadequate for safe spinal anesthesia with metycaine, and it was eventually prohibited in all hospitals.

That these restrictions constitute an advance in anesthesia may be debatable; however, there can be no doubt that they did, and will, make local and regional procedures much safer.

CHOICE OF METHODS

Patients in military hospitals can be divided into two major groups; those undergoing reconstructive or other elective surgery in rear areas, and casualties. The first group are usually young men in good physical condition and the choice of methods or agents presents few problems. Intravenous, regional, and spinal (in that order) were the most popular technics; all were well tolerated, though a number of observations were made on the high incidence of pulmonary complications following spinal anesthesia. Institutions that were acting as training centers used more inhalation anesthesia.

In the combat zone casualties were classified as transportable, or non-transportable. Transportable casualties were ten times as common and included simple wounds, compound fractures, and other injuries to the extremities that could be splinted and evacuated by ambulance to the rear for surgery. These patients were not in severe shock, and their injuries were essentially minor. Evacuation Hospitals, where most of these cases were treated, had to handle a very large volume of surgery with a minimum of trained anesthetic supervision and therefore over half of these cases were anesthetised with sodium pentothal; local and regional methods were used in an additional 30 per cent. Field blocks were

found to be inadequate in that complete debridement was not always possible which resulted in an increase in subsequent infection. Specific regional blocks were preferable; brachial plexus blocks proved very practical. Pentothal established itself as an invaluable agent for these minor cases.

Non-transportable casualties comprised those severely shocked, with multiple injuries, or severe wounds of head, chest, or abdomen. They required superlative anesthetic management under difficult combat conditions close to the front lines. Inhalation anesthesia with nitrous oxide-ether was found to be the anesthesia of choice and was used in the majority of these cases. Pentothal and spinal were contraindicated on account of shock; for multiple injuries inhalation was found to be more practical than regional procedures, though for simple procedures block anesthesia was used and was the second commonest method employed. For major cranial, thoracic, and abdominal surgery an endotracheal technic was found to be very satisfactory.

SHOCK

The improved treatment of shock was one of the most brilliant accomplishments of military surgery. The provision and timely use of adequate amounts of human plasma, and later, whole blood, was possible for the first time in history. Plasma and blood in the ratio of two to one were given rapidly till the circulatory depression was overcome. This, together with the use of oxygen and other supportive treatment, literally snatched back from the grave thousands who otherwise would have perished. In anesthetising patients recovering from shock, it was observed that a profound morphine effect ensued as the improved circulation mobilized the drug from the site where it had been injected.

DIAGNOSTIC AND THERAPEUTIC NERVE BLOCKS

The war gave a great impetus to the use of nerve blocking for diagnosis and therapy. Many wounds of the extremities caused marked vasomotor disturbances which could be relieved by producing a vasodilatation by blocking the appropriate sympathetic trunk. That mysterious syndrome, the causalgic state, could often be alleviated by a sympathetic block with procaine or alcohol, or if sympathectomy was contemplated, would afford an indication of the degree of relief to be expected. Many other obscure pains could be relieved by nerve block of either sympathetic or spinal nerves, or information obtained thereby to indicate the origin. Infiltration anesthesia proved a useful treatment for sprains and very helpful for the reduction and transport of simple fractures.

Many advances in anesthesia have resulted from the war, some of which have been described. If in this description the splendid record of the Department of Medicine and Surgery of the Navy seems to have been overlooked, it is not because their contributions have been insignificant, but solely due to the author's ignorance. These contributions to medicine must be adequately publicized, therefore, that we may apply them in our daily practice so that the hours of arduous work, the privations and hardships, dangers, wounds, and even deaths of these heroic anesthetists who so well served anesthesia and their country, shall not be in vain.

SUMMARY

Contributions made by the war to the advancement of anesthesia included:

1. The placement of the professional anesthetist in a key position in the military hospital organization.
2. An educational program that increased by fifty per cent the number of available anesthetists.
3. A revival in the use of nitrous oxide.
4. A demonstration that sodium pentothal is safe only when used for short, minor operations on patients in good condition.
5. Showing that inhalation anesthesia with ether, or nitrous oxide-ether was the anesthesia of choice for those in shock.
6. Confirming procaine as the safest all-round local agent.
7. Pentothal proved to be the most practical anesthesia for transportable casualties, regional was second choice.
8. For non-transportable casualties inhalation anesthesia produced best results. Endotracheal methods in major cranial, thoracic, and abdominal operations were lifesaving.
9. Plasma and blood transfusions were responsible for saving many from death from shock.
10. Nerve blocking was emphasized as a valuable diagnostic and therapeutic procedure.

BIBLIOGRAPHY

1. Wood, Paul: Personal communication.
2. Tovell, Ralph: Anesthesiology in E.T.O. News Letter of American Society of Anesthesiologist, IX, 6, pg. 2, Dec.,1945.
3. "Anonymous", Pentothal Anesthesia Bulletin of the U. S. Army Medical Department, May, 1944, Ibid: May, 1945.
4. Local Anesthetic Agent: War Department Technical Bulletin, TB MED 43, May 18, 1944.

Neurodermatitis

In specific skin diseases, such as psoriasis or neurodermatitis, where emotional trauma or contact agents of occupational origin may provoke a transitory flare-up or exacerbation of the disease, a period of compensability should be strictly limited by law. Following this period of liability, the employer should be discharged of responsibility for any future recurrences, such as are apt to occur during the course of either of these or related diseases, and which are unrelated to the single occupational exposure.—Oscar L. Levin, M.D., and H. T. Behrman, M.D., New York State Jrnl. of Medicine, Vol. 46, No. 19, October 1, 1946.

Pharmacology and Therapeutc Aspects of Goiter Thiourea and Thiouracil

H. NORBERT CAVANAUGH, M. D., and CORNELIUS B. DeCOURCY, M. D.

A TOTALLY new concept in the medical treatment of hyperthyroidism has evolved since 1943. This avenue of attack employs drugs that have the faculty of inhibiting thyroid endocrine function. After much trial to determine which chemical compound produced the inhibition with the least toxicity, two substances were developed, thiourea and thiouracil. Relief of hyperthyroid symptoms, and the return of serum cholesterol and the basal metabolic rate to normal, occur after the administration of either drug. Thiouracil is about three times more active than thiourea. There is a latent period of one to two weeks before these effects are observed, a sustained remission during treatment, and a return of hyperthyroidism when treatment is discontinued.[1]

The theory has been advanced that thiouracil inhibits the synthesis of the thyroid hormone by preventing or suppressing the utilization of iodine in thyroid hormone synthesis. The resulting thyroid insufficiency stimulates the anterior pituitary to produce a compensatory but ineffectual hyperplasia of the secretory cells of the thyroid. Clinically this is evidenced by a lowering of the metabolic rate and an increase in the size and vascularity of the thyroid. The increased vascularity increases operative difficulty which in a measure can be avoided by discontinuing thiouracil and substituting iodine for a week or so preoperatively.[2]

THIOURACIL—DANGERS

So potentially useful, a new agent demanded thorough controlled investigation especially since early reports indicated that toxic and even fatal reactions might follow the drugs' administration. As a result, two exhaustive cooperative studies were made.[3, 4]

Summarizing both surveys, one concludes that although thiouracil (the favored drug) presents distinct advantages in the treatment of hyperthyroidism, occasionally providing complete relief of hyperthyroidism by medical treatment alone, toxic symptoms are so frequent that much care must be exercised and therapy must be abandoned in 10 to 13 per cent of all cases so treated.

The larger study was made on 5,745 cases, treated by 328 investigators. This was supervised by the Food and Drug Administration and reported to the Council on Pharmacy and Chemistry of the American Medical Association.[3]

The most serious complication is a **granulocytopenia** which occurs in abut 2.5 per cent of cases. This difficulty tends to arise during the early weeks of therapy, 80 per cent of cases developing by the twelfth week. Fortunately, this disorder is frequently relieved by massive doses of penicillin—500,000 units per day.

Other complications are: **leukopenia** with an incidence of 4.4 per cent, three fourths of the cases occurring in the first eight weeks of therapy; **drug fever**, incidence 2.7 per cent, 85 per cent showing in the first four weeks of treatment, the earlier the worse; and **skin reactions** (3.3 per cent), including urticaria, scleroderma-like changes, and a wide variety of dermatoses. Jaundice, purpura, and anemia have been reported. None of these complications appears to bear any direct relation to the quantity of drug employed.

The smaller investigating group, representing one English and eleven American major universities, studied 1,091 cases.[4] They list 0.5 per cent fatalities directly attributable to the drug. Among the many complications, they include: glandular enlargement, oral sepsis, ankle edema, albuminuria, jaundice, psychotic manifestations, diminished platelet count, and profound myxedema. Previous thiouracil or concomitant sulfonamide therapy appears to increase the risk of leukocyte depression.

THIOURACIL PRECAUTIONS

The present optimum dosage schedule for thiouracil is 0.4 Gm. per day in divided doses initially. After symptoms are controlled or the basal metabolic rate falls within normal limits,

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the dose is reduced to 0.1 Gm. to 0.2 Gm. per day.

The investigators stress that thiouracil is of no value and should not be used in other derangements of thyroid activity or in conditions not associated with hyperthyroidism. The recommendation is that the drug should only be used for preoperative treatment or for those patients upon whom thyroidectomy is contraindicated. They note that many patients, particularly those who have received previous iodine therapy do not respond immediately to thiouracil therapy. Medication should, therefore, be continued for at least thirty days, or with patients who have received iodine, for sixty to one hundred and twenty days before concluding that thiouracil is ineffective.

THIOURACIL CONCLUSIONS

Despite the complications, three fourths of the larger group of investigators felt that the incidence of adverse reactions of thiouracil was less than the incidence of complications from present methods of treatment.

Editorially, the *Annals of Internal Medicine* reaches the following conclusion:

". . . . thiouracil is a potentially dangerous drug which should not be used at present except in patients who can be carefully supervised, particularly with reference to leukocytes and platelets. Furthermore, this supervision can not be relaxed after a few weeks or months of treatment even though the incidence of each reaction is then less. With such care, thiouracil apparently constitutes a reasonably safe and highly effective means of controlling hyperthyroidism, at least temporarily. . . ."[5]

Our own opinion at present is that thiouracil should be confined only to the preparation of patients for thyroidectomy, and not for the medical treatment of hyperthyroidism because of the many complications. We feel that its use is indicated principally in those cases which have become "iodine-fast" because of prolonged use of iodine, or in those cases in which thyroidectomy is contraindicated.

BIBLIOGRAPHY

1. Astwood, E. B.: J.A.M.A., 122:78, 1943
2. Editorial: N. Y. State Jr. Med., 45:1894, 1945.
3. Van Winkle, et al.: J.A.M.A., 130:343, Feb. 9, 1946.
4. Moore, F. D.: J.A.M.A., 130-315; Feb. 9, 1946.
5. Editorial: Ann. Int. Med., 22:448, 1945.

Health

Health is not an inalienable right. It is a privilege. Privileges invariably entail equivalent responsibilities. It is so easy to accept privileges that before long mankind takes them for granted and claims them for inherent rights. Nature grants few rights, preferring to demand that privileges be earned. Health, like freedom and peace, continues only as we exert ourselves wisely to maintain it. Edward J. Stieglitz, M.D., A Future for Preventive Medicine.

Physiologic Treatment of Pulmonary Emphysema

Although cases of chronic bronchitis and pulmonary emphysema have been treated with penicillin with favorable results, especially those in which hemolytic streptococcus of pneumococcus organisms were found on culture, many other patients with pulmonary emphysema manifest a mucoid expectoration without evidence of significant infection. In some patients who sought penicillin therapy the employment of measures to promote bronchial relaxation, oxygen therapy, as well as other forms of physiologic therapy produced sufficiently good clinical results as to render unnecessary the trial of antibiotic measures. Whether or not patients with pulmonary emphysema show signs of bronchial spasm by examination of the lungs, such as sibilant rales, the presence of prolonged expiration is an indication for the use of measures which produce bronchial relaxation.

Although epinephrine and ephedrine have been recognized as valuable in the treatment of bronchial spasm in patients with this disease the effective employment of aminophyllin has received little attention. The administration of aminophyllin by mouth on an empty stomach is a valuable method of producing relaxation of the bronchi in a considerable proportion of patients with pulmonary emphysema, frequently resulting in marked decrease in cough, expectoration and exertional dyspnea. The dosage now employed is 0.2 gram immediately on arising and again at 3 to 4 in the afternoon. In some cases the morning dose is 0.3 gram if the patient can tolerate this amount without nausea. The administration of aminophyllin in larger dosages may be given rectally by dissolving 0.6 to 0.7 gram in 25 cc. of water and instilling it with a glass syringe and catheter.

Ephedrine may be found preferable in some patients to aminophyllin and may be given in a dosage of 25 mg. on arising, after breakfast and at 3 p.m. It is generally not given at night because it may maintain a wakeful state, although this effect may be counteracted when administered with 75 mg. of amytal or 0.1 gm. phenobarbital. In patients who have become refractory to aminophyllin ephedrine is substituted, and, in those patients who respond less and less well to ephedrine, aminophyllin is employed. In many cases refractoriness to ephedrine and aminophyllin does not develop and under these circumstances almost complete disappearance of cough and marked improvement in dyspnea take place when a capsule containing aminophyllin 0.2 or 0.3 combined with ephedrine 25 mg. is administered on arising and at 3 p.m.—Alvan L. Barach, M.D., New York Medicine, Vol. II, No. 19, October 5, 1946.

Proceedings of The Council

Large Volume of Business Transacted at Fall Meeting Held at Granville; Public Relations Policies Established; Plans Laid for 1947 Meeting; Veterans Problems Discussed

THE regular Fall meeting of The Council of the Ohio State Medical Association was held at the Granville Inn, Granville, Ohio, on September 20, 21, and 22, 1946. All members of The Council were present with the exception of Dr. Ross Knoble, Sandusky, who was unable to attend because of illness. In addition to members of The Council, the conference was attended by Dr. B. J. Hein, Toledo, Chairman of the Committee on Public Relations and Economics; Dr. Jonathan Forman, Editor of *The Journal;* and Secretaries Nelson, Saville, and Page.

Following are the minutes of the sessions of The Council held during the three days, at which the President, Dr. McNamee, presided:

The minutes of meetings of The Council held on May 6 and 8 and on June 9 **were approved,** on **motion** by Dr. Lincke, seconded by Dr. Rutledge, and **carried.**

MEMBERSHIP STATISTICS

The Executive Secretary reported on membership as follows: Total membership as of September 19, 1946, 7,062, compared to a total membership on December 31, 1945, of 6,904. Of the membership as of September 19, 805 members were being carried on the roster through waiver of dues, having been separated from the services during the present calendar year or still in the services. By official action, the policy of waiving dues for members in the services was extended for the year 1947.

Members of The Council reported on activities and problems in their respective districts, each offering constructive suggestions on activities which might be revived or initiated in order to stimulate interest and action among the county medical societies.

MORE FIELD WORK PLANNED

The Executive Secretary reported that the staff of the State Headquarters Office is planning more field work among the county societies. Also, he reported that action has been started to revive the Speakers' Bureau to provide speakers for county society meetings on request and that suggestions for practical county society programs are being assembled and will be distributed to county medical society officers and program chairmen in the near future.

ANNUAL MEETING PLANS

There was a general discussion of the recent 1946 Annual Meeting. Members of The Council expressed themselves as feeling that the meeting was very successful and one of the finest ever held by the Association and appropriate in every way for a celebration of the 100th Anniversary of the Association.

A financial statement on the Annual Meeting was presented by the Executive Secretary, showing that income exceeded expenditures in the amount of $2,526.81.

NEW SECTIONS CREATED

Reference was made to Resolution J, adopted by the House of Delegates at the 1946 meeting, authorizing the establishment of a Section on the General Practice of Medicine.

On **motion** by Dr. Schriver, seconded by Dr. Micklethwaite, and **carried.** The Council authorized the establishment of such a section for the 1947 Annual Meeting. The following section officers for the new section were named by The Council: Chairman, Dr. J. Craig Bowman, Upper Sandusky; Secretary, Dr. J. G. Lemmon, Akron.

Several communications, asking the Ohio State Medical Association to create a Section on Anesthesiology, were read and discussed.

On **motion** by Dr. Dixon, seconded by Dr. Swartz, and **carried,** such a section was created. The following officers for the new section were named by The Council: Chairman, Dr. A. A. Brindley, Toledo; Secretary, Dr. R. J. Whitacre, Cleveland.

CLEVELAND AUDITORIUM SELECTED

The Executive Secretary reported that preliminary arrangements for the 1947 Annual Meeting in Cleveland, May 6, 7, and 8, had been completed as follows: Hotel Cleveland will be the headquarters hotel; the House of Delegates will meet at Hotel Cleveland; registration headquarters, the technical exhibit, and all program sessions will be held at the Cleveland Public Auditorium. On **motion** by Dr. Brindley, seconded by Dr. Swartz, and **carried,** the foregoing arrangements **were approved** by The Council.

SUGGESTIONS ON PROGRAM

Following a prolonged discussion on the type of meeting which should be held in 1947, The Council, on **motion** by Dr. Rutledge, seconded by Dr. Davis, and **carried,** adopted the following recommendations for consideration by the Committee on Scientific Work:

1. Section meetings should be held, including

sessions of the newly created Section on the General Practice of Medicine and the Section on Anesthesiology.

2. In addition to the technical exhibit, efforts should be made to present selected scientific exhibits and exhibits on educational features of medicine and public health, such exhibits to be obtained from physicians and various organizations, societies, etc., directly interested in the field of health.

3. That time during the meeting be set aside for presentation to all in attendance of information and discussions on various social economic, and legislative matters of interest and importance to the medical profession.

4. That a dinner meeting for members of the House of Delegates be arranged for Tuesday evening, May 6, and that the final session of the House of Delegates be scheduled for Thursday morning, May 8.

PRE-ELECTION CONFERENCES

There was a detailed discussion and exchange of ideas on activities prior to the general election on November 5. Reports from local legislative chairmen, based on interviews with candidates, were discussed and analyzed.

On **motion** by Dr. Brindley, seconded by Dr. Micklethwaite, and **carried**, the Executive Secretary was instructed to arrange for pre-election conferences in the various Councilor Districts to be attended by the officers and legislative committeemen of the county medical societies.

On **motion** by Dr. Swartz, seconded by Dr. Rutledge, and **carried**, the President was authorized to send a letter to all members of the Ohio State Medical Association, urging active participation in pre-election activities and urging members to obtain copies of the booklet, "The 25 To Keep Alive", for distribution to their parents, clubs, and other organizations. In the same motion, the Executive Secretary was instructed to send one of the booklets to each candidate for the Ohio Legislature and the Congress.

PUBLIC RELATIONS DISCUSSIONS

That part of the meeting devoted to the discussion of public relations activities of the Association for the remainder of this year and for 1947 was opened by Dr. B. J. Hein, chairman of the Committee on Public Relations and Economics. Dr. Hein reported on activities in the field of public relations which are being carried on or contemplated by the American Medical Association.

Mr. Saville, Director of Public Relations for the State Association, offered some tangible and constructive suggestions. Also, he reported on public relations activities which are being carried on in some of the other state medical societies, notably California, Oklahoma, and Michigan. All members of The Council expressed themselves on activities which might be undertaken, some of them offering suggestions in writing.

GENERAL POLICY DRAFTED

On **motion** by Dr. Rutledge, seconded by Dr. Dixon, and **carried**, The Council instructed the Committee on Public Relations and Economics and Director of Public Relations Saville to take all suggestions offered under consideration, and adopted the following general preliminary statement of policy pertaining to the public relations program of the Association:

1. That newspapers and radio should be used on a paid basis, if necessary, when vital issues arise and where it is necessary to get proper information to the public promptly.

2. That a special speakers' bureau of physicians be established to provide well-qualified speakers on social, economic, and legislative questions for lay groups and for medical societies.

3. That up-to-date literature and pamphlets on these subjects be prepared by the State Association for distribution to physicians and the public.

4. That county medical societies be urged to take a greater active interest in formulating proper contacts with organizations, groups, and public officials within their counties in order that proper guidance might be given to medical and health activities of groups outside the medical profession.

Dr. Davis discussed the possibility of closer cooperation with the members of the Woman's Auxiliary on matters of public relations. It was pointed out that the Auxiliary is anxious to assist the State Association on such matters but might need some financial help on specific projects.

On **motion** by Dr. Schriver, seconded by Dr. Davis, and **carried**, the Woman's Auxiliary Advisory Committee was instructed to explore the needs and problems of the Woman's Auxiliary and report back to The Council at a future date.

COMMITTEE ON EXTENSION OF ACTIVITIES

The President stated that he felt it would be a good idea to have a special committee make a survey of the present activities of the Association and to report back to The Council with recommendations for extending the functions, services, and activities of the Association. On **motion** by Dr. Dixon, seconded by Dr. Tronstein, and **carried**, the appointment of such a committee by the President was authorized.

VETERANS PROBLEM DISCUSSED

A conflict in policy between the Veterans Administration and the Ohio State Medical Association on the present Ohio program for the medical care of veterans was discussed at length.

Correspondence with General Bradley, General Hawley, and others, and directives issued by the Veterans Administration were reviewed. It was the sense of The Council that the present procedure of the Veterans Administration in not allowing veterans to select a physician in private practice in all instances where a veteran makes such a request was in conflict with the agreement between the Ohio State Medical Association and the Veterans Administration as it is interpreted and understood by The Council.

After various courses of possible action had been discussed, The Council, on **motion** by Dr. Swartz, seconded by Dr. Brindley, and **carried**, requested Dr. Schriver, the Past-President, Dr. Harry V. Paryzek, Chairman of the Committee on Medical Care of Veterans, and the Executive Secretary to go to Washington for the purpose of conferring with General Bradley and General Hawley on this matter in an effort to try to work out a mutually agreeable policy and procedure.

A communication from the Buckeye Orthopedic Club, to the effect that the present Veterans Administration fee schedule under the Ohio agreement for orthopedic examinations and treatment is inadequate, was referred, on **motion** by Dr. Worstell, seconded by Dr. Micklethwaite, and **carried**, to the Committee on the Medical Care of Veterans for consideration and conference with representatives of the Buckeye Orthopedic Club.

FINANCIAL QUESTIONS

Information regarding an increase of rent for the headquarters office in Columbus and the need for additional space and personnel was presented by the Executive Secretary.

On **motion** by Dr. Swartz, seconded by Dr. Davis, and **carried**, the Executive Secretary was instructed to negotiate an agreement with the owners of the Hartman Theater Building for the present offices and additional space, if available, for 1947.

On **motion** by Dr. Brindley, seconded by Dr. Tronstein, and **carried**, the Executive Secretary was authorized to investigate the possibilities of securing necessary new personnel and to report his findings at the December meeting of The Council.

The question of establishing a retirement plan for the employees of the Association, which has been under consideration for approximately two years, was discussed.

On **motion** by Dr. Swartz, and seconded by Dr. Micklethwaite, the Committee on Auditing and Appropriations was authorized to enter into an agreement for a retirement plan. An amendment offered by Dr. Bowman, seconded by Dr. Dixon, and **carried**, provided that the State Association should pay the entire cost of the retirement plan and that the plan should apply to all employees with at least five years of service with the Association.

REPORT ON RURAL HEALTH

A report from the Committee on Rural Health was presented on behalf of the committee by the Executive Secretary. In this connection it was pointed out that 50 counties had returned the questionnaire indicating whether or not there is a need for additional physicians in the county.

Following a general discussion, the recommendations of the Committee on Rural Health, as set forth in the report, **were approved** on **motion** by Dr. Clodfelter, seconded by Dr. Dixon, and **carried.**

Following a general discussion, it was the sense of The Council that it would not be feasible to have postgraduate lectures throughout the state this Fall and Winter, but that the Committee on Education should begin to lay plans for postgraduate programs in 1947, working more closely with Ohio's three medical schools on such matter.

REPORT ON LEGISLATION

The Executive Secretary reported on the latest developments in Washington and on bills enacted in the field of health by the recent Congress. Also, he reported on bills of interest enacted at the recent special session of the Ohio General Assembly.

Pursuant to a request from the American Medical Association, the Executive Secretary was instructed, on **motion** by Dr. Lincke, seconded by Dr. Messenger, and **carried**, to forward suggestions, criticisms, and comments of members of The Council regarding the so-called Taft Bill, S. 2143.

A request from the officials of the Division of Aid for the Aged, asking for the assistance of the Association in setting up schedules which might be used by the Division in administering a recent amendment which permits an allowance up to $200 in any calendar year for extraordinary medical, dental, optometrical, or hospital services needed by an old-age pensioner, was presented to The Council.

On **motion** by Dr. Lincke, seconded by Dr. Swartz, and **carried**, The Council recommended that the Veterans Administration fee schedule now in effect in Ohio be used as a minimum for the allowances referred to and that the local offices of the Division of Aid for the Aged be requested to ask the local medical society to establish a local medical advisory committee to assist the Division on medical and health matters.

POLICY ON CRIPPLED CHILDREN PROGRAM

Communications pertaining to a request of the Department of Public Welfare that various hospitals engaged in providing services for crippled children agree to provide diagnostic services for

any child regardless of economic status, were discussed at length.

The following resolution, adopted by the Buckeye Orthopedic Club of Ohio on September 14, 1946, was read:

"We, the members of the Buckeye Orthopedic Club of Ohio are opposed to the principle of free diagnostic clinics for all. On the other hand, we stand ready, now as in the past, to give our services freely to those in need. We reserve the right, now as in the past, to value our services according to the financial status of the patient.

"We are opposed to all inclusive agreements which fail to take into consideration the individual problem of the patient."

Previous action of The Council taken in March, 1945, was reviewed. After a general discussion, The Council, on **motion** by Dr. Rutledge, seconded by Dr. Swartz, and **carried**, adopted the following statement of policy:

"Referral of children to diagnostic clinics or hospitals should be made by the attending or family physician.

"The Council is opposed to payment by governmental agencies for diagnosis and treatment involving those who can afford to pay for such services.

"It is recommended that members of the Association refuse to participate in any program which conflicts with the principles set forth above, but should continue to make their services available to all needing such services on a private patient-physician relationship, basing charges, if any, on the financial status of the patient or his parents."

POLIO PLAN DISCUSSED

Information regarding an agreement between the National Foundation for Infantile Paralysis and the Ohio Department of Welfare on activities involving treatment of persons afflicted with poliomyelitis was presented to The Council and the following resolution, adopted by the Buckeye Orthopedic Club of Ohio on September 14, 1946, was read and discussed:

"It has been brought to our attention that there is a pending agreement between the National Foundation for Infantile Paralysis and the State Department of Welfare, whereby voluntarily contributed funds will be utilized by the department for the care of poliomyelitis patients. It is our feeling that the use of such voluntary contributions by a tax-supported agency is highly unsatisfactory and will not result in the maximum use of the funds raised including the extra costs of hospitalizing such patients.

"We agree fully that there is deficient follow-up care under the present in-co-ordinated system now in effect. Since the use of voluntary funds by a State agency will be objected by many, we strongly advise that this defect be corrected in the following manner:

"1. That the nurses of the Welfare Department be specifically hired to render follow-up services to these patients.

"2. That at the conclusion of primary hospital care of the acute and convalescent periods that such children as stand in need of further physical aid be considered as ordinary crippled children.

"3. That such children thereafter, when in need, may be committed to the State Department of Welfare as in the case of any ordinary crippled child.

"4. Further, impressed by the entire lack of uniformity, rules of hospitalization, and treatment of these patients under the individual chapters of the National Foundation for Infantile Paralysis, we strongly advise that representatives of each chapter in the State of Ohio be called together to form a State organization to include medical representation of pediatricians, orthopedic surgeons, and physicians of physical medicine which shall establish uniform rules, procedures, and costs for the care of such patients."

On **motion** by Dr. Worstell, seconded by Dr. Swartz, and **carried**, the resolution adopted by the Orthopedic Club was endorsed and adopted by The Council as the official policy of the State Association on this question.

EPILEPSY PROGRAM ENDORSED

A communication from the Ohio Society for Crippled Children, asking for the advice, counsel, and cooperation of the Ohio State Medical Association in establishing an educational program on epilepsy, was considered.

On **motion** by Dr. Swartz, seconded by Dr. Lincke, and **carried**, the project as outlined was approved in principle and the Ohio Society for Crippled Children requested to seek the advice and guidance of representatives of the Association in working out details.

Attention was called to the fact that the stockholders of Ohio Medical Indemnity, Inc., would meet in Columbus on Wednesday, October 2.

On **motion** by Dr. Davis, seconded by Dr. Worstell, and **carried**, the President of the Association was instructed to cast the votes, which the Association is entitled to as a stockholder, for a list of nominees for the Board of Directors of Ohio Medical Indemnity, Inc., suggested by members of The Council during a discussion of this subject.

COMMIMTTEE SUGGESTIONS

Dr. McNamee asked for suggestions from members of The Council as to physicians who might be appointed on a committee to be known as the Committee on Military Service. This committee, which would be similar to a committee established

by the American Medical Association, would study communications received and suggestions made by physicians who served in the Armed Forces during World War II and would formulate recommendations of the medical profession regarding utilization of the services of physicians in any future national emergency. Numerous suggestions were made by members of The Council and were taken under consideration by the President.

The President also made a similar request for suggestions regarding an Advisory Committee to the Division of Venereal Diseases of the Department of Health, and members of The Council presented suggestions which also were taken under consideration by the President.

MISCELLANEOUS BUSINESS

On **motion** by Dr. Rutledge, seconded by Dr. Micklethwaite, and **carried,** the changes in the constitution and by-laws of the Montgomery County Medical Society, adopted recently by that society, **were approved.**

On **motion** by Dr. Tronstein, seconded by Dr. Lincke, and **carried,** the constitution and by-laws adopted recently by the Noble County Medical Society, which had been inactive for a number of years, **were approved**

On **motion** by Dr. Dixon, seconded by Dr. Lincke, and **carried,** the Executive Secretary and Business Manager of *The Journal* was authorized to work out an increase in the advertising rates of *The Journal,* effective January 1, 1947, in line with recommendations received from Mr. Alfred J. Jackson, Director, Cooperative Medical Advertising Bureau, Chicago.

Mr. Saville reported on the recent National Cooperative Congress held in Columbus and called attention to an article appearing in the October issue of *The Ohio State Medical Journal.* Proofs of the article were distributed to members of The Council.

A communication from an insurance agent was read and discussed.

On **motion** by Dr. Davis, seconded by Dr. Micklethwaite, and **carried,** The Council expressed itself as believing that it was not the business of The Council to lend the endorsement of the Association to projects of this kind and that the question of group accident and sickness insurance was a matter to be decided by individual physicians or local medical societies.

A communication from the American Medical Association, requesting this Association to establish a Committee on Mental Hygiene and take a greater interest in mental hygiene activities, based on a resolution presented by the Ohio delegates at the recent session of the American Medical Association, was read and discussed.

On **motion** by Dr. Brindley, seconded by Dr. Dixon, and **carried,** the President was authorized to appoint a Committee on Mental Hygiene.

A communication from the Ohio State Nurses' Association, calling attention to the action by that Association at its recent convention registering opposition to the Wagner-Murray-Dingell Bill, was read.

On **motion** by Dr. Rutledge, seconded by Dr. Messenger, and **carried,** The Council commended the Nurses' Association on this action and instructed the Executive Secretary to communicate this sentiment to the officials of the Nurses' Association.

A communication from the California State Medical Association, pointing out that a resolution opposing Federalized medicine would be presented at the annual convention of the American Legion in San Francisco the last week in September, was read. The letter requested the Ohio State Medical Association to contact representatives of the Ohio Legion to the convention on this matter.

On **motion** by Dr. Bowman, seconded by Dr. Swartz, and **carried,** the Executive Secretary was instructed to convey to the Ohio Legion's delegates a request from the Ohio State Medical Association that they give serious consideration to the proposed resolution and support it if at all possible.

A memorandum from the Ohio Department of Health regarding child health conferences was read and discussed.

On **motion** by Dr. Swartz, seconded by Dr. Bowman, and **carried,** the question was referred to the Committee on Public Relations and Economics for further study.

A communication from the Ohio Department of Health, asking the Association to endorse the department's tuberculosis case-finding program through the use of mobile X-ray units, was read.

On **motion** by Dr. Schriver, seconded by Dr. Lincke, and **carried,** The Council endorsed the program, providing the precedures follow the principles outlined in the action taken by The Council on March 25, 1945, on chest surveys.

Dr. Davis presented a resolution which would authorize the creation of an Ohio Board of Certification for the General Practice of Medicine to be patterned after a similar Board created in the State of Indiana. Members of The Council believed that it would be premature to take such action at this particular time and instructed the Executive Secretary to send copies of the resolution and a copy of the Indiana setup, if available, to members of The Council for study until the next meeting of The Council.

There being no further business, The Council adjourned to meet at the call of the President.

Attest: CHARLES S. NELSON,
Executive Secretary.

Your Suggestions for Improving Ohio Program for Medical Care of Veterans Solicited; Write Columbus Office

LIKE all programs in their infancy, the Ohio Program for Medical Care of Veterans is not working as smoothly as officials of both the Ohio State Medical Association and the Veterans Administration had anticipated.

Efforts are being made by both organizations to solve the problems which have arisen. Some of the complications can be attributed to administrative flaws; too much paper work; errors in judgment on the part of some personnel of the Veterans Administration; debatable policies of the Veterans Administration in handling authorizations; inequities in parts of the fee schedule; misunderstandings on the part of some physicians; lack of information on the part of some physicians; failure on the part of some physicians to comply with regulations; incomplete and inaccurate reports on examinations and treatments, etc.

In the near future conferences will be held at which representatives of the Veterans Administration and the Ohio State Medical Association will analyze these and other questions and endeavor to work out mutually satisfactory methods of correcting them.

All physicians who have been participating in the Veterans Medical Care program can assist in finding solutions for troublesome questions which have arisen if they will send to the Columbus Office of the Ohio State Medical Association criticisms and recommendations.

In offering comments, physicians are urged to make constructive suggestions; how administrative procedures or policies might be modified to make the program operate more efficiently.

Every suggestion received will be given careful consideration by officials of the State Medical Association prior to the contemplated conferences with officials of the Veterans Administration.

Specific points and cases should be cited—generalities are of little value. State the problem or problems which you have encountered and suggest solutions.

Here is an opportunity for more than 4,000 Ohio physicians who are listed as fee-designated physicians to speak up and have a part in working out changes which will improve the Ohio program.

Tentative Plans Made by Committee for Program of 1947 Annual Meeting in Cleveland on May 6, 7, and 8

A MEETING of the Committee on Scientific Work was held at the State Headquarters Office on Sunday, September 29, 1946. The following members of the committee were in attendance: Dr. Louis G. Herrmann, Cincinnati, chairman; Dr. Homer D. Cassel, Dayton; Dr. M. Paul Motto, Cleveland; Dr. Charles A. Doan, Columbus; and Dr. Martin W. Diethelm, Toledo. In addition to members of the committee, the following also attended the meeting: Dr. E. P. McNamee, Cleveland, President; Dr. R. L. Rutledge, Alliance, President-Elect; Dr. Jonathan Forman, Columbus, Editor of *The Journal*; and Secretaries Charles S. Nelson, George H. Saville, and Hart F. Page.

There was a general discussion of the 1946 Annual Meeting. It was the opinion of the committee that, in general, the meeting was well arranged and the program good. However, members of the committee stated that a number of members had indicated that they felt future programs should feature practical talks and instructional courses. All members expressed themselves as believing that an effort should be made to make considerable modification in the type of program for 1947.

AUDITORIUM ENGAGED

The Executive Secretary reported on the arrangements for the 1947 Annual Meeting, which will be held May 6, 7, and 8, in Cleveland. He stated that the Cleveland Auditorium had been engaged for the exhibits and the various sessions, except sessions of the House of Delegates which will be held at Hotel Cleveland, designated as the Headquarters Hotel.

A report from The Council, in which were incorporated various suggestions regarding the 1947 Annual Meeting, was received. The report stated that The Council had authorized the creation of two new sections, namely: a Section on the General Practice of Medicine and a Section on Anesthesiology; and that the following officers had been appointed for such sections, respectively: Dr. J. Craig Bowman, Upper Sandusky, chairman; Dr. J. G. Lemmon, Akron, secretary; and Dr. A. A. Brindley, Toledo, chairman; and Dr. R. J. Whitacre, East Cleveland, secretary.

RECOMMENDATIONS OF THE COUNCIL

The chief recommendations made by The Council for consideration of the committee were:

"1. Section meetings should be held, including sessions of the newly created Section on the General Practice of Medicine and the Section on Anesthesiology.

"2. In addition to the technical exhibit, efforts should be made to present selected scientific exhibits and exhibits on educational features of medicine and public health, such exhibits to be obtained from physicians and various organizations, societies, etc., directly interested in the field of health.

"3. That time during the meeting be set aside for presentation to all in attendance of information and discussions on various social, economic, and legislative matters of interest and importance to the medical profession.

"4. That a dinner meeting for members of the House of Delegates be arranged for Tuesday evening, May 6, and that the final session of the House of Delegates be scheduled for Thursday morning, May 8."

The committee then discussed the general setup for the 1947 Annual Meeting.

INNOVATIONS PLANNED

It was the sense of the committee that instructional courses should be set up for each day of the meeting, which would provide practical suggestions which the men could use in their daily practices and which would be designed primarily for those in general practice.

It was suggested that mimeographed synopses of the high spots of the various talks should be distributed to the audiences. These would be especially important in listing information as to dosages, prescriptions, etc., it was pointed out.

After discussion, the committee recommended to President McNamee that he send a letter to the section officers, suggesting that each section have a program committee, of which the chairman and secretary would be members ex officio, for the purpose of arranging the section programs in 1947.

The committee decided to meet again on Sunday, November 17, 9:30 a. m., and have the officers of the sections and the chairman of the program committee of each section, recommended above, present for the purpose of discussing the 1947 program generally and to receive instructions on setting up section programs and schedules.

The committee then worked out the following tentative schedule for the 1947 Annual Meeting:

TUESDAY, MAY 6

8:00-9:30 A.M. **Instructional Courses.**

(Seven courses to be given. The first 45 minutes of each would be a lecture and the second

45 minutes would be a panel discussion and questions and answers. Each course to be limited to 100 persons. Applications for the courses to be filed in advance of the Annual Meeting. Admission to courses to be by ticket only. Tickets to be issued only to members. No fee to be charged.)

10:00 A.M. **First General Session.**
10:00-10:20 A.M. Address.
10:25-10:45 A.M. Address.
10:50-11:10 A.M. Address.
11:15-11:35 A.M. Address.
11:40-12:00 Noon. Address.
12:00-2:00 P.M. **Lunch and Visiting Exhibits.**
2:00 P.M. **Section Meetings.**
Section on Surgery.
Section on Pediatrics.
Section on Eye, Ear, Nose and Throat.
Section on Nervous and Mental Diseases.
6:00 P.M. **House of Delegates Dinner and First Session.**
8:30 P.M. **Second General Session.**
Program to be devoted to discussion of public relations, rural health, legislation, etc., to be arranged by the various committees of the State Association.

WEDNESDAY, MAY 7

8:00-9:30 A.M. **Instructional Courses.**
(Rules governing courses given on Tuesday to apply.)
10:00 A.M. **Third General Session.**
10:00-10:20 A.M. Address.
10:25-10:45 A.M. Address.
10:50-11:10 A.M. Address.
11:15-11:35 A.M. Address.
11:40-12:00 Noon. Address.
12:00-2:00 P.M. **Lunch and Visiting Exhibits.**
2:00 P.M. **Section Meetings.**
Section on Medicine.
Section on Obstetrics and Gynecology.
Section on Anesthesiology.
Section on Public Health.
7:00 P.M. **Banquet.**

THURSDAY, MAY 8

8:00-9:30 A.M. **Instructional Courses.**
(Rules governing courses on Tuesday and Wednesday to apply.)
10:00 A.M. **Section on the General Practice of Medicine.**
10:00-10:20 A.M. Address.
10:25-10:45 A.M. Address.
10:50-11:10 A.M. Address.
11:15-11:35 A.M. Address.
11:40-12:00 Noon. Address.
12:00 Noon. **Luncheon for House of Delegates and Final Session of House.**

HAVE YOU ORDERED SUPPLY OF "THE 25 TO KEEP ALIVE"?

Have you written the State Headquarters Office for an additional supply of the attractive booklet "The 25 To Keep Alive"? Many of your colleagues have. They are placing copies in their waiting rooms, and have distributed copies to members of luncheon clubs and other civic groups. Public reaction is splendid. The people who know about it, like the constructive "Health Program for Ohio" adopted by the House of Delegates at Columbus last May. More people should know about it, including your patients, friends, and acquaintances. The Ohio State Medical Association will furnish as many copies free of charge as you can put to good use. The address is: 1005 Hartman Theatre Bldg., Columbus 15.

Dr. L. Howard Schriver Elected By Associated Medical Care Plans, Inc.

Dr. L. Howard Schriver, Cincinnati, past president of the Ohio State Medical Association and president of Ohio Medical Indemnity, Inc., was elected president of Associated Medical Care Plans, Inc., at a meeting held in the A.M.A. headquarters building October 5.



L. H. SCHRIVER, M.D.

Operating as a nonprofit corporation under the laws of the State of Illinois since April of this year, the object of Associated Medical Care Plans is to promote the establishment and operation of voluntary prepayment medical care plans throughout the United States and Canada and to co-ordinate the activities of existing plans.

Dr. Schriver succeeds Dr. F. E. Feierabend of Surgical Care, Inc., Kansas City. The following officers were re-elected: William M. Bowman, executive director of the California Physicians' Service, vice-president; Dr. Norman M. Scott, executive director of Medical Surgical Plan, New Jersey, treasurer; and Jay C. Ketchum, executive director of Michigan Medical Service, secretary.

Now Is the Time To Get Your Hotel Space for 1947 Annual Meeting, May 6-8, Cleveland

IT isn't too early to make hotel reservations for the 1947 Annual Meeting of the Ohio State Medical Association, to be held in Cleveland, May 6, 7, and 8.

The scientific sessions and the technical exhibits will be located in the spacious Cleveland Municipal Auditorium. Meetings of the House of Delegates will be held at the Hotel Cleveland, headquarters hotel, also headquarters for the Woman's Auxiliary.

In order to insure obtaining the type of accommodations you desire in the hotel of your choice, make a selection now from the list of hotels appended. Complete the reservation blank at the bottom of the page and **mail it directly** to the hotel management.

You'll look forward to the meeting with greater anticipation if you have a confirmed hotel reservation in your file.

NAME AND LOCATION	No. of Rooms	Single	Double	Double Twin Beds
CLEVELAND Public Square (Headquarters Hotel)	1000	$3.00-$7.00	$4.50-$9.00	$6.00-$12.00
ALLERTON Chester at E. 13th St.	550	2.65- 4.50	4.00- 6.50	5.00- 7.50
AUDITORIUM St. Clair at E. 6th St.	300	2.00- 3.50	4.00- 6.00	4.50- 7.00
CARTER Prospect at E. 9th St.	600	4.00- 7.00	6.00- 8.00	7.00- 9.00
HOLLENDEN 610 Superior Ave., NE	1000	3.00- 5.00	4.50- 6.50	5.00- 12.00
OLMSTED Superior at E. 9th St.	250	3.00- 5.00	5.00- 7.00	6.00- 8.00
STATLER Euclid at E. 12th St.	1000	3.00- 6.00	5.00- 8.00	5.00- 8.00

HOTEL RESERVATION BLANK

Mail this coupon to hotel selected

Manager _____ Hotel, Cleveland, Ohio.

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, May 6, 7, and 8, 1947, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double Room with bath Price: _____

☐ Twin Bed Room with bath ☐ Suite

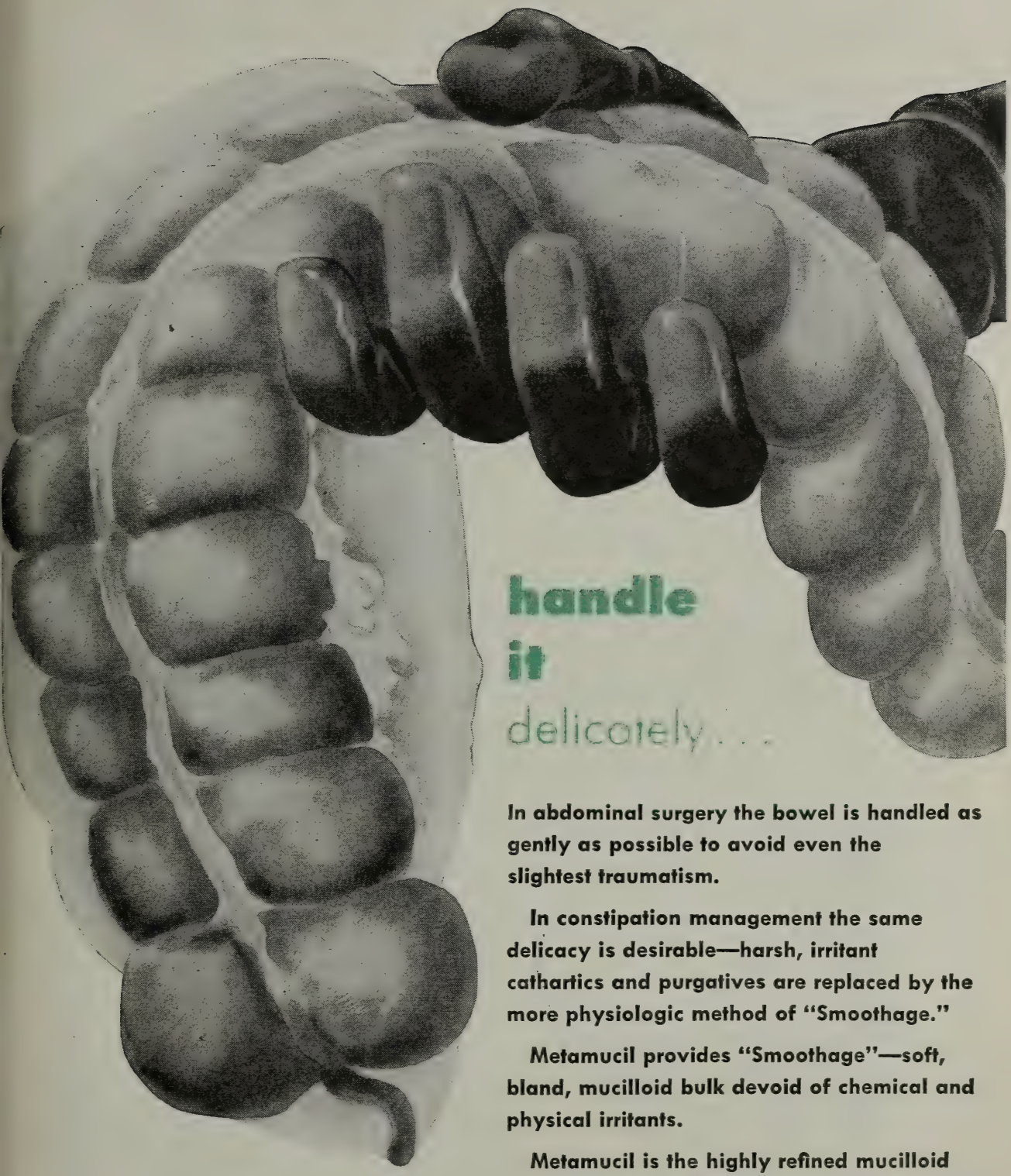
Arriving May _____ at _____ A.M. _____ P.M.

PLEASE VERIFY MY RESERVATION.

Name _____

Address _____

_____



handle
it
delicately . . .

In abdominal surgery the bowel is handled as gently as possible to avoid even the slightest traumatism.

In constipation management the same delicacy is desirable—harsh, irritant cathartics and purgatives are replaced by the more physiologic method of "Smoothage."

Metamucil provides "Smoothage"—soft, bland, mucilloid bulk devoid of chemical and physical irritants.

Metamucil is the highly refined mucilloid of a seed of the psyllium group, Plantago ovata (50%), combined with dextrose (50%).

Metamucil is the registered trademark of G. D. Searle & Co., Chicago 80, Illinois

SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

Activities To Find Solutions for Health and Medical Problems of Rural Areas Initiated by Committee

ACTIVITIES have been launched by the Committee on Rural Health of the Ohio State Medical Association which, the committee hopes, will develop ways and means of making improved medical and health services available for those residing in the rural areas of Ohio.

At a recent meeting of the committee, it formulated a prospectus for its work, in which were set forth the following questions which will be studied as they all have an important bearing on the over-all question of rural health services and facilities:

QUESTIONS BEING STUDIED

1. Economic and social conditions of the community.
2. Facilities available for physicians.
3. Education of students and younger physicians regarding the advantages of rural practice.
4. Better postgraduate opportunities for physicians in rural areas.
5. Methods whereby physicians in rural areas will have opportunities for membership on staffs of hospitals in adjacent communities.
6. Closer relationships between physicians who have been established in rural areas and younger physicians just locating in the area.
7. Modern trend in medical education whereby too few graduates enter the general practice of medicine.
8. To determine whether communities can or can not support a hospital or diagnostic center.
9. Programs whereby rural physicians will have good consultation services readily available.
10. Establishment of general practitioners' section on hospital staffs of hospitals in rural areas or hospitals serving rural areas.
11. Improvement of official health services and programs of health education.

POLL OF AREAS TAKEN

Realizing the need for up-to-date data on communities which need a physician or additional physicians, the committee is conducting a survey through the county medical societies. This survey will provide information on areas needing a physician; distance of area from nearest active physician; distance from nearest hospital; estimated population of trading area; need for specialists; etc.

The committee is planning an early conference with officials of Ohio's three medical schools to discuss the problems of rural medical and health services. At this conference, the following matters will be considered:

CONFERENCE PLANNED

1. Possibility of a survey of senior students and interns regarding their views on rural practice. Information will be sought on how many students and interns are interested in locating in a rural area; if not, why; would the student or intern consider rural practice if certain inducements were to be offered; what inducements.

2. Possibility of the medical schools devoting more emphasis to the need for physicians in rural communities.

3. Possibility of lectures by representatives of the Ohio State Medical Association to medical students on subjects relating to rural health and medical practice as well as on general economic and social subjects bearing on the practice of medicine.

4. Possibility of establishing externships to provide assistants for physicians in rural practice and to give students an insight into rural practice.

5. Closer relationship between the medical schools and the Ohio State Medical Association on postgraduate education in order to furnish physicians in rural areas with more opportunities for postgraduate work.

6. Establishment of a program which would make regular consultation services readily available to physicians in rural communities.

After these preliminary steps have been completed or are well along, the committee will then be able to make specific recommendations as to programs and actions which the State Association and its component county societies should inaugurate in an effort to provide the answers to some of the problems which exist.

TO WORK WITH RURAL GROUPS

The committee hopes to work closely with representatives of organized farm groups, seeking their advice and suggestions and offering the advice and suggestions of the committee to such organizations which are approaching the problem through educational activities among residents of farm communities.

The services of the committee will be made available to those interested in obtaining new hospitals for regions without a hospital or in the enlargement of present hospitals. The feasibility and desirability of establishing diagnostic centers in certain sections of the state also will be studied.

Moreover, the committee will work with officials of existing voluntary prepaid medical and hospital care plans for the purpose of stimulating



BETTER BABY FEEDING

with

Campbell's STRAINED BABY SOUPS

Q. Will Baby like these soups?

A. If he is like most babies, he will. Mothers who have tried Campbell's Strained Baby Soups say that they are better-tasting—that Baby takes them readily and appears to enjoy their tempting, normal flavors. Each soup retains to the utmost the natural flavors of the meats and vegetables employed. The texture is smooth and the consistency uniform and pleasing to the infant.

Q. Why five kinds?

A. Doctors agree that it's important to get Baby accustomed to a variety of flavors early in life, so that he will accept all foods readily and will not develop "fussy" eating habits. Also, it takes many different foods to supply the approximately 40 nutrients needed for infant development and energy—hence we use vegetables and a cereal in the preparation of each one of our four meat soups.

Q. What about vitamin and mineral retention?

A. The latest scientific information has been drawn upon in developing a cooking method which insures the efficient conservation of vitamins and the retention of minerals. A comprehensive analysis of each soup may be had upon application to Campbell Soup Company, Camden, N. J.

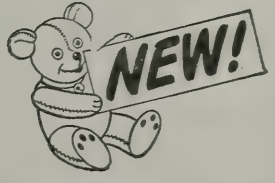
5 KINDS:

CHICKEN
BEEF
LAMB
LIVER
VEGETABLE

All in Glass Jars



Campbell's Strained Baby Soups represent fine quality . . . in ingredients . . . in care and method of cooking . . . in retention of minerals and conservation of vitamins . . . *and in good flavor.* Every resource of Campbell's Kitchens is devoted to that aim.



LOOK FOR THE RED-AND-WHITE LABEL

rapid extension of the coverages offered by these plans into rural areas.

HEALTH EDUCATION PROGRAMS

Another activity which will be undertaken by the committee is to cooperate with official and non-official health organizations in providing health education programs for farm people and in improving the facilities and services of health departments serving rural communities.

The members of the committee are: Dr. Carll S. Mundy, Toledo, chairman; Dr. Jonathan Forman, Columbus; Dr. W. B. Recker, Leipsic; Dr. E. G. Caskey, Mineral Ridge; Dr. William B. .Taylor, Jackson; Dr. James M. Snider, Marysville; Dr. H. T. Pease, Wadsworth; Dr. A. D. Harvey, Lebanon; and Dr. L. E. Anderson, Greentown.

Cincinnati Academy Outlines 10-Point Health Program

The Academy of Medicine of Cincinnati, at its October 15th meeting, unanimously adopted a "positive" 10-point health program for the City of Cincinnati and Hamilton County, which had been presented by the Academy's committee on medical economics.

Dr. L. Howard Schriver, past-president of the Ohio State Medical Association and a member of the Academy, strongly urged that the organization use some of its financial resources to promote the program, and thus foster good relationship between the medical profession and the community.

Points outlined in the plan are:

1. Improved housing and slum eradication.
2. Smoke abatement.
3. Extension of recreational facilities.
4. A sound school health program.
5. A comprehensive program for industrial health.
6. Firm regulations for traffic safety and the means to secure it by education of the driving public and elimination of traffic hazards by public authority.
7. Adequate financial support for the Board of Health in its entire program, and especially with reference to rat elimination, tuberculosis, venereal disease, and communicable disease control.
8. An improved parole system, particularly as it affects the criminally insane, sex offenders, and perpetrators of crimes of violence.
9. Support of the finest medical and nursing education.
10. Adequate hospital and convalescent home facilities.

Members of the committee include, Dr. Robert C. Rothenberg, chairman; Dr. Charles W. Beaman, Dr. George C. Bishop, Dr. Joseph A. Freiberg, Dr. Harry L. Fry, Dr. Helen I. Glueck, Dr. Edward J. McGrath, and Dr. Leo A. Smyth.

O.S.M.A. TO EXHIBIT AT A.P.H.A. AND OHIO WELFARE CONFERENCE MEETINGS

The staff of the Bureau of Public Relations of the Ohio State Medical Association will present the Association's "Twenty-five To Keep Alive" exhibit at two important meetings during the month of November.

Copies of the booklet "The Twenty-five To Keep Alive", which contains the 25-point health program for Ohio, adopted by the House of Delegates of the Association during the centennial anniversary meeting in May, will be distributed, and a member of the staff will be present to explain the program to visitors.

At Cleveland, November 12-14, the display will be shown at the 74th Annual Meeting of the American Public Health Association. It will occupy Booth 331 in the scientific exhibits, located in the Cleveland Public Auditorium.

From November 17 through 20 the exhibit will be shown at the 56th Annual Meeting of the Ohio Welfare Conference, Deshler-Wallick Hotel, Columbus.

American Legion Votes To Oppose Compulsory Health Insurance

The American Legion has taken a definite stand against compulsory health insurance, a resolution expressing its views on this type of legislation having been unanimously approved by the delegates to the 28th National American Legion Convention, in San Francisco, October 4.

Text of the resolution follows:

WHEREAS: Veterans who have served in the armed forces now have available to them hospital and medical care provided by the United States Government; and

WHEREAS: There are countless voluntary health insurance plans now being offered by the physicians and the insurance companies; and

WHEREAS: Proposed plans of compulsory health insurance would increase the tax burden and bring about regimentation of the medical profession; and

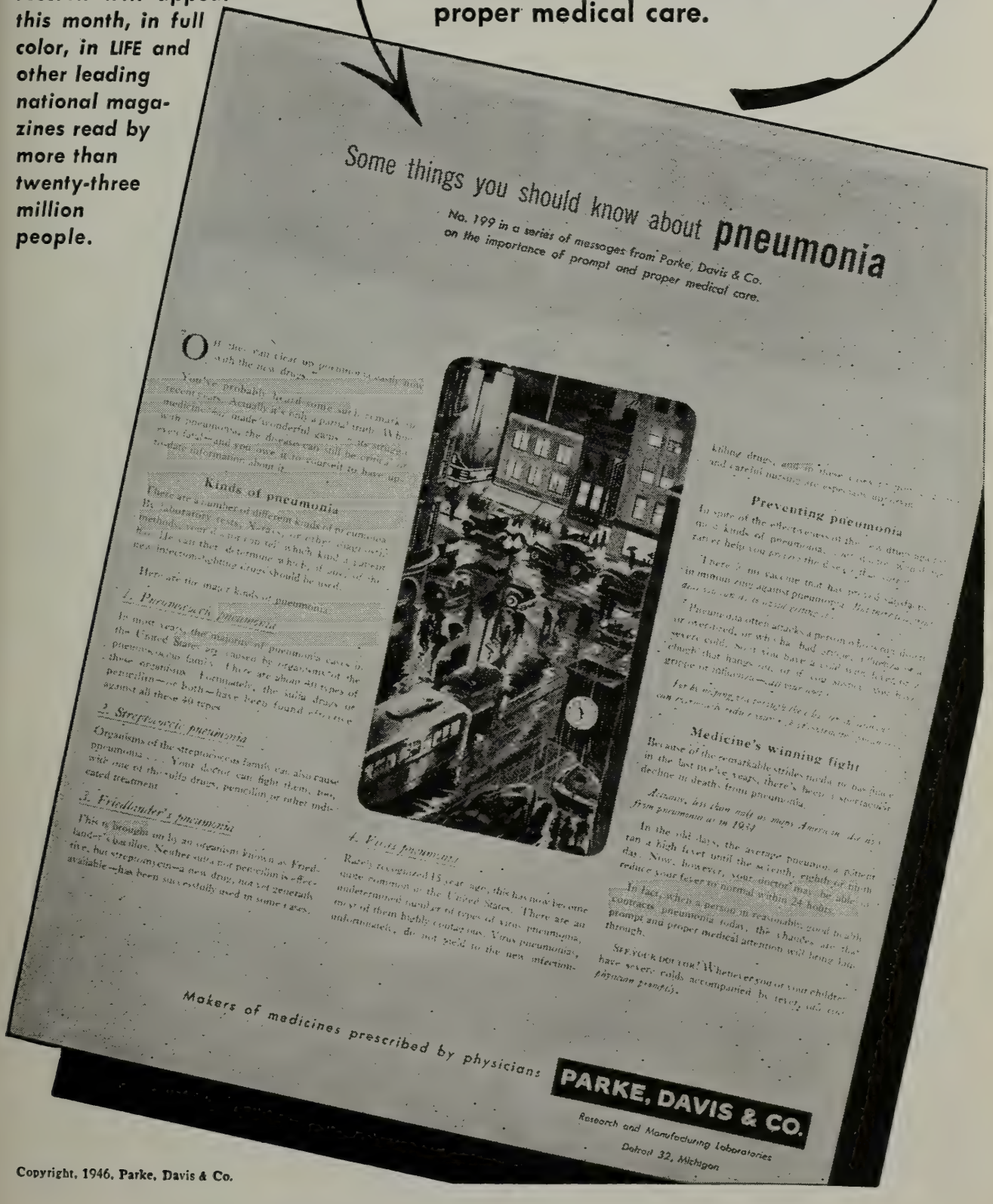
WHEREAS: All forms of compulsion are repugnant to our American way of life since our liberties and opportunities would be circumscribed;

NOW, THEREFORE, BE IT RESOLVED: That the National Assembly of the American Legion hereby expresses its opposition to compulsory health insurance.

This timely message in behalf of the medical profession will appear this month, in full color, in LIFE and other leading national magazines read by more than twenty-three million people.

"See Your Doctor"

This is the 199th advertisement in the Parke-Davis series on the importance of prompt and proper medical care.



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Election Issues and Qualifications of Candidates Are Discussed at Conferences in Councilor Districts

A PRE-ELECTION Conference of presidents, secretaries, and chairmen of legislative committees of county medical societies, the district councilor, district legislative committeeman, and a member of the staff of State Headquarters Office of the Ohio State Medical Association, was held in each Councilor District during the period of October 4 to 11.

The purpose of the evening conferences was to discuss the issues of the November 5 election and to exchange information concerning candidates for national and state offices, their general qualifications, attitudes on medical and public health questions, and voting records, if any.

Methods were suggested for disseminating information on the candidates by county society officers to the membership generally.

Following is a list of the conferences, with names of those who attended:

First District: Oct. 4, Academy of Medicine Auditorium, Cincinnati. Dr. E. O. Swartz, Cincinnati, councilor; Dr. Emil R. Swepston, Cincinnati, district legislative committeeman; Adams—Dr. Robert B. Ellison, Peebles, and Dr. Sam Clark, Cherry Fork; Butler—Dr. Earl C. Leyrer, Hamilton; Clermont—Dr. Allan B. Rapp, Owensville; Clinton—Dr. Robert Conard and Dr. Kelley Hale, Wilmington; Hamilton—Dr. C. E. Hauser, Dr. D. C. Rivers, and Mr. Raymond A. Swink, Cincinnati.

Second District: Oct. 11, Assembly Room, Piqua National Bank, Piqua. Dr. H. C. Messenger, Xenia, councilor; Dr. G. A. Woodhouse, Pleasant Hill, district legislative committeeman; Champaign—Dr. V. R. Frederick and Dr. Isador Miller, Urbana; Clark—Dr. S. C. Yinger and Dr. D. W. Hogue, Springfield; Miami—Dr. Russell Gardner, Troy, and Dr. J. T. Quirk, Piqua; Montgomery—Dr. N. E. Leyda and Dr. W. A. Ricketts, Dayton; Shelby—Dr. H. C. Clayton, Sidney.

Third District: Oct. 8, High School Building, Ada. Dr. J. Craig Bowman, Upper Sandusky, councilor; Dr. Floyd M. Elliott, district legislative committeeman; Allen—Dr. F. A. Hemsath, Lima; Hancock—Dr. O. P. Klotz, Findlay; Logan—Dr. R. E. Traul, Bellefontaine.

Fourth District: Oct. 7, Wellington Hotel, Napoleon. Dr. A. A. Brindley, Toledo, councilor; Dr. D. J. Slosser, Defiance, district legislative committeeman; Fulton—Dr. A. M. Wilkins, Delta, and Dr. L. C. Cosgrove, Swanton; Henry—Dr. R. L. Gilson and Dr. J. R. Bolles, Napoleon; Dr. E. C. Mohr, Dr. R. J. Borer, Dr. A. S. Avery, Dr. W. W. Green, and Mr. Robert Elwell, Toledo; Ottawa—Dr. Alfred D. Miessner, Dr. C. R. Wood, and Dr. G. A. Poe, Port Clinton; Paulding—Dr. Ray Mouser, Paulding, and Dr. K. C. Evans, Payne; Putnam—Dr. W. B. Recker, Leipsic; Williams—Dr. P. G. Meckstroth, Bryan; Wood—Dr. D. R. Barr, Grand Rapids.

Fifth District: Oct. 9, Acdaemy of Medicine, Cleveland. Dr. Fred W. Dixon, Cleveland, councilor; Dr. Ralph M. Watkins, chairman, subcommittee on legislation; Cuyahoga—Dr. D. M. Keating, Dr. John W. Conwell, and Mr. H. Van Y. Caldwell, Cleveland; Lake—Dr. Morris G. Carmody, Painesville.

Sixth District: Oct. 8, Alliance Country Club. Dr. Ralph L. Rutledge, Alliance, President-Elect, Ohio State Medical Association; Dr. Paul A. Davis, Akron, councilor; Mahoning—Dr. Wm. M. Skipp, Youngstown; Stark—Dr. L. E. Anderson, Greentown; Summit—Dr. Richard A. Gregg and Dr. Robert M. Lemmon, Akron; Trumbull—Dr. E. L. MacDougall, Warren, and Dr. E. G. Caskey, Mineral Ridge.

Seventh District: Oct. 10, Buckeye Hotel, Uhrichsville. Dr. Carl A. Lincke, Carrollton, councilor; Dr. Jay Calhoon, Uhrichsville, district legislative committeeman; Belmont—Dr. W. Miles Garrison, St. Clairsville; Carroll—Dr. W. G. Lyle, Minerva; Coshocton—Dr. H. H. Schwindt, West Lafayette; Tuscarawas—Dr. Max Shaweker, Dover, and Dr. C. J. Miller, New Philadelphia.

Eighth District: Oct. 11, University Club, Zanesville. Dr. Arthur J. Tronstein, Newark, councilor; Dr. R. G. Plummer, Newark, district legislative committeeman; Guernsey—Dr. O. R. Jones, Cambridge, and Dr. M. S. Lawrence, Quaker City; Licking—Dr. Paul C. Grove and Dr. James K. Nealon, Newark; Muskingum—Dr. A. C. Ormond, Zanesville; Perry—Dr. W. D. Porterfield, Junction City, and Dr. H. F. Minshull and Dr. C. B. McDougal, New Lexington.

Ninth District: Oct. 10, City Council Chamber, Jackson. Dr. Gilbert Micklethwaite, Portsmouth, councilor; Dr. Clyde M. Fitch, Portsmouth, district legislative committeeman; Hocking—Dr. H. G. Southard, Logan; Jackson—Dr. John L. Frazer, Dr. W. B. Taylor, and Dr. C. C. Fitzpatrick, Jackson, and Dr. H. W. Gillen, Wellston; Meigs—Dr. R. E. Boice, Middleport; Pike—Dr. L. E. Wills, Waverly; Scioto—Dr. George D. Blume, New Boston, and Dr. Garnet E. Neff, Dr. T. G. McCormick, Dr. Dow Allard, and Dr. Oscar R. Micklethwait, Portsmouth.

Tenth District: Oct. 9, State Headquarters Office, Ohio State Medical Association, Columbus. Dr. H. M. Clodfelter, Columbus, councilor; Dr. Donald F. Bowers, Columbus· district legislative committeeman; Delaware—Dr. A. R. Callander, Delaware; Franklin—Dr. Horace B. Davidson and Dr. John M. Thomas, Columbus; Knox—Dr. Charles Baldwin, Centerburg, and Dr. John L.

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stable

intranasal antibiotic

Quicker acting, more penetrating and more stable than penicillin is tyrothricin, the nontoxic antibacterial principle of 'Prothricin' Antibiotic Nasal Decongestant. Applied locally, tyrothricin promptly attacks bacteria, and its low surface tension promotes penetration of tissue crevices and mucosal folds.

Moreover, tyrothricin maintains antibiotic efficiency even in the presence of pus or mucus, and since (unlike penicillin) it is sparingly absorbed, local activity is prolonged.

In addition to tyrothricin (0.02%), 'Prothricin' Antibiotic Nasal Decongestant contains an effective vasoconstrictor, 'Propadrine' hydrochloride* (1.5%), to help re-establish normal drainage without the unpleasant side-effects characteristic of ephedrine and its analogs.

Isotonic with normal nasal secretions, buffered in the physiologic pH range of 5.5-6.5, 'Prothricin' decongestant is clear and free-flowing, does not impair ciliary function, and (unlike sulfonamide suspensions) does not form mucosal crusts that may block drainage.

Finally, 'Prothricin' Antibiotic Nasal Decongestant is stable, retaining full antibacterial potency indefinitely at room temperature. This unique preparation is indicated in the local treatment of sinusitis, rhinitis, coryza and nasal congestion.

Supplied in 1-ounce, dropper-assembly bottles.

*Council-Accepted

SHARP & DOHME

'PROTHRICIN'

antibiotic nasal decongestant

Baube and Dr. John C. Drake, Mt. Vernon; Madison—Dr. G. C. Scheetz, West Jefferson; Pickaway—Dr. George W. Heffner, Circleville; Ross—Dr. M. D. Scholl and Dr. Ralph W. Holmes, Chilliothe; Union—Dr. James M. Snider, Marysville.

Eleventh District: Oct. 7, Samaritan Hospital, Ashland. Dr. George F. Linn, Norwalk, district legislative committeeman; Ashland—Dr. L. G. Sheets and Dr. R. L. Shilling, Ashland; Erie—Dr. David R. Lehrer, Sandusky; Lorain—Dr. Swen Nielsen, Elyria; Richland—Dr. George L. Evans and Dr. Charles R. Keller, Mansfield; Wayne—Dr. R. N. Wright and Dr. J. B. Beeson, Wooster.

Charles S. Nelson, Executive Secretary of the State Association, attended the meetings at Cleveland, Uhrichsville, Zanesville, Alliance, and Ashland, and George H. Saville, Assistant Executive Secretary, was at Cincinnati, Piqua, Ada, Napoleon, Columbus, and Jackson.

Christmas Seal Campaign in Ohio To Open on November 25

The 40th Annual Christmas Seal Campaign will begin in Ohio on November 25, and continue through Christmas. Its purpose is to raise funds to support the work of the National Tuberculosis Association, the Ohio Tuberculosis and Health Association, and 88 county-wide health associations in their fight against tuberculosis.

Proceeds of the sale in Ohio last year were



$925,000. This year's goal is $1,027,000. The funds are distributed as follows: eighty-seven per cent is retained by the local group for use in the community where the seals are sold; five per cent goes to the National Tuberculosis Association; and the remainder to the Ohio Tuberculosis and Health Association.

Better Get Your Atlantic City Hotel Immediately

A list of Atlantic City hotels, schedule of rates, map showing locations and an "application for hotel accommodations" appear on advertising pages 74 and 75 of the October 19, 1946 issue of The Journal of the A.M.A. It is important that those desiring hotel accommodations for the centennial meeting of the A.M.A., June 9-13, 1947, use the form in The Journal and send it not direct to the hotel but to Dr. Robert A. Bradley, Chairman, Subcommittee on Hotels, 16 Central Pier, Atlantic City, N. J. All hotel assignments will be cleared through Dr. Bradley's committee, even though addressed to an individual hotel. Applications should be sent as soon as possible and several choices of hotels given, as indicated in the application form.

New Series of Radio Transcriptions Available from A. M. A.

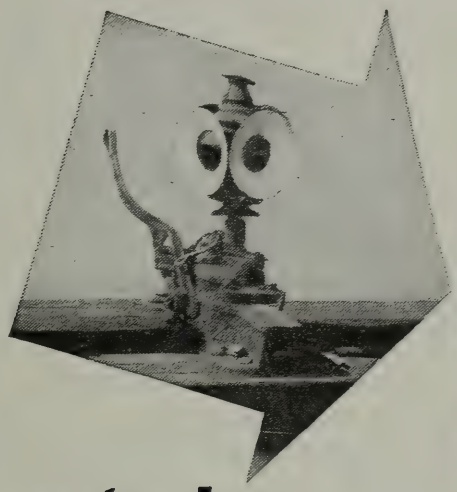
The Section on Pediatrics of the American Medical Association in cooperation with the Bureau of Health Education has produced a series of electrically transcribed 15-minute radio programs entitled "Keeping Your Baby Well". This is the 14th series prepared under the direction of this bureau, bringing the total to 180 programs.

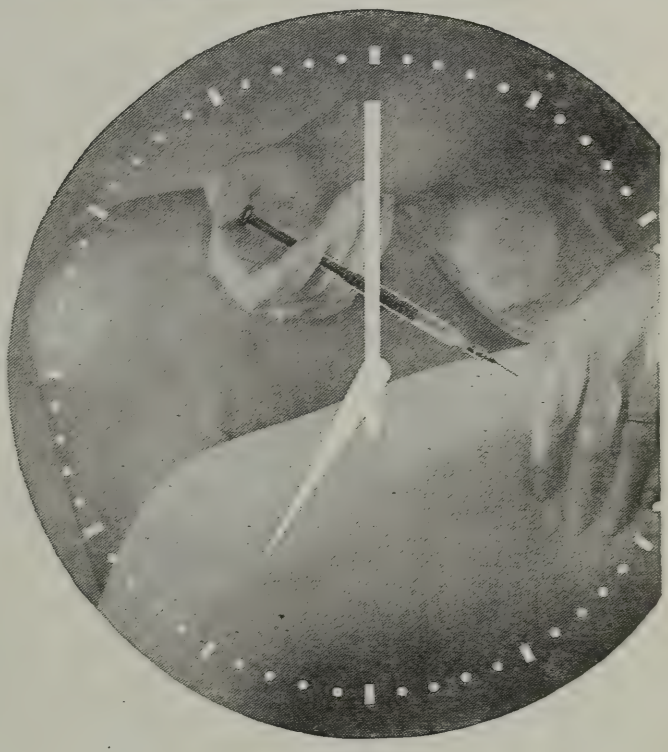
More than 4,000 local broadcasts on more than 120 radio stations have been made from these transcriptions. Each program is summarized by Dr. W. W. Bauer, Director of the Bureau of Health Education. They are available to any local medical society, health departments, or other health agencies. All others wishing to borrow the transcriptions should procure approval from the local medical society. There is no charge connected with the loan except the expense of express shipment to return the records.

These transcriptions, featuring interviews with 20 pediatricians selected by the officers of the section, include the following topics and speakers:

1. You and Your Baby, C. Anderson Aldrich, Rochester, Minn.
2. The Premature Baby, Julius H. Hess, Heyworth N. Sanford, and A. H. Parmalee, Chicago.
3. Keeping Our Babies Well, Borden S. Veeder, St. Louis.
4. Breast Feeding Is Best, W. C. C. Cole, Detroit.
5. Artificial Feeding Can Be Good, Clara M. Davis, Winnetka, Ill., and Henry Gerstenberger, Cleveland.
6. Babies Who Fail to Gain, C. W. Burhans, Cleveland.
7. Overweight Babies, R. L. Kennedy, Rochester, Minn., and J. E. Gonce, Madison, Wis.
8. Vomiting and Diarrhea, M. K. Miller, South Bend, Ind., and F. C. Rodda, Minneapolis.
9. Vitamins, J. A. Bigler, Highland Park, Ill.
10. Allergy, Ben Z. Rappaport, Chicago.
11. Care of the Baby's Skin, W. L. Crawford, Rockford, Ill., and Abraham B. Schwartz, Milwaukee.
12. Tonsils In or Out, Stanley Gibson and George S. Livingston, Chicago.
13. Child Poisonings, John Aikman, Rochester, N. Y.







a switch in time

A SWITCH to 'Wellcome' Globin Insulin with Zinc can often save the annoyance of a second or third daily insulin injection—for in many cases the patient's needs can be supplied with *only one injection a day* of this unique intermediate-acting insulin. Three distinct steps provide the welcomed change-over:

1. THE INITIAL CHANGE-OVER DOSAGE: The first day, 30 minutes or more before breakfast, give a single dose of Globin Insulin, equal to ½ the total previous daily dose of protamine zinc insulin or of protamine zinc insulin combined with regular insulin. The next day, dose may be increased to ⅔ former total.

2. ADJUSTMENT TO 24-HOUR CONTROL: Gradually adjust the Globin Insulin dosage to provide 24-hour control as evidenced by a fasting blood sugar level of less than 150 mgm. or sugar-free urine in the fasting sample.

3. ADJUSTMENT OF DIET: Simultaneously adjust carbohydrate distribution of diet to balance insulin activity; initially 2/10, 4/10 and 4/10. Any midafternoon hypoglycemia may usually be offset by 10 to 20 grams carbohydrate at 3 to 4 p.m. Base final carbohydrate adjustment on fractional urinalyses.

Most mild and many moderately severe cases may be controlled by *one daily injection of 'Wellcome' Globin Insulin with Zinc.* Vials of 10 cc.; 40 and 80 units per cc. Developed in The Wellcome Research Laboratories, Tuckahoe, New York. U.S. Pat. 2,161,198. Literature on request.

'Wellcome' Trademark Registered

'WELLCOME' Globin Insulin WITH ZINC

BURROUGHS WELLCOME & CO. (U.S.A.) INC., 9 & 11 EAST 41ST STREET, NEW YORK 17, N.Y.

More Voluntary Medical Care Plans Given Approval of A. M. A.

EIGHTEEN additional voluntary prepayment medical care plans, sponsored by state and county medical organizations, have been granted the seal of acceptance by the Council on Medical Service of the American Medical Association, bringing to 27 the number approved so far.

This approval gives the 18 plans, as well as the nine previously approved, the right to use the American Medical Association blue shield emblem on all official papers and on any promotional literature or display material.

80 PLANS OPERATING

More than 80 voluntary plans sponsored by medical organizations are now operating and E. J. McCormick, M.D., Toledo, chairman of the Council, said applications for approval had been received from many of them and would be acted upon soon.

The 18 plans approved at a recent meeting of the Council's executive committee are:

Physicians Association of Clackamas County, Oregon City, Oregon; Hospital Service Corporation, Birmingham, Alabama; Florida Medical Service Corporation, Jacksonville; North Idaho Medical Service Bureau, Lewiston; Genesee Valley Medical Care, Rochester, N. Y.; Hospital Saving Association of North Carolina, Chapel Hill; Oklahoma Physicians Service, Tulsa; Coos Bay Hospital Association, Coos Bay, Oregon; Pacific Hospital Association, Eugene, Oregon; Klamath Medical Service Bureau, Klamath Falls, Oregon; Group Medical and Surgical Service, Dallas, Tex.; The Dallas County Medical Plan, Dallas, Tex.; Surgical Care, Inc., Roanoke, Va.; Medical-Surgical Service, Inc., Clarksburg, W. Va.; Marion County Medical Service, Inc., Fairmont, W. Va.; Medical-Surgical Care, Inc., Parkersburg, W. Va.; the West Virginia Medical Service, Wheeling; and the Hospital Service Association, Oakland, Calif.

The nine plans originally approved are:

California Physicians' Service, San Francisco; Iowa Medical Service, Des Moines; Michigan Medical Service, Detroit; Surgical Care, Inc., Kansas City, Mo.; Nebraska Medical Service, Omaha; Medical-Surgical Plan of New Jersey, Newark; Ohio Medical Indemnity, Inc., Columbus; Medical Surgical Association of Pennsylvania, Harrisburg; and the Oregon Physicians Service, Salem.

At another session, the Insurance Committee of the Council on Medical Service, meeting with representatives of leading insurance organizations in America, created two sub-committees—a committee on cooperation and a committee on rural enrollment. The purpose of the first is to enlist close cooperation among all voluntary groups for rendering health protection while the second subcommittee will study the best means of affording protection offered by the combined voluntary facilities to people in rural areas.

VOLUNTARY PLANS LAUDED

"The people of America can best obtain protection against the hazards of illness through voluntary health insurance plans," said A. W. Adson, M.D., Rochester, Minn., adding: "Through cooperation and understanding among physicians, voluntary medical care and hospital plan executives and insurance representatives can best provide this coverage for the American people without the interference, red tape, and government control which would come with compulsory sickness insurance."

Besides Dr. Adson, members of the sub-committee on cooperation are James R. Miller, M.D., Hartford, Conn., a member of the board of trustees of the American Medical Association and Lester Perry, executive director, Medical Service Association of Pennsylvania, Harrisburg. Ex officio members are Jay C. Ketchum, Detroit, executive vice-president of the Michigan Medical Service and advisor to the Council; Frank Dickinson of the A. M. A. Bureau of Medical Economic Research, and Howard Brower of the A. M. A. Council on Medical Service.

PROTECTION IN RURAL AREAS

Members of the sub-committee to study voluntary health protection in rural areas are James R. McVay, M.D., Kansas City, Mo.; F. S. Crockett, M.D., Lafayette, Ind., chairman of the A. M. A. Committee on Rural Health; and L. S. Kleinschmidt, of the Council on Medical Service. Mr. Dickinson was appointed as ex officio member.

Thomas A. Hendricks, Chicago, executive secretary of the Council, said that an invitation would be extended to the Blue Cross Commission of the American Hospital Association and the American Hospital Association itself to be represented on both committees.

Private insurance organizations will also be represented on both sub-committees. These will include representatives from the Health and Accident Underwriters Conference, the American Mutual Alliance, the Life Insurance Association of America, and the Association of Casualty and Surety Executives.

On O. S. U. Board

Five Ohio physicians have been selected to serve during 1946-1947 on the alumni board of advisors of the Ohio State University College of Medicine, according to Dr. Russel G. Means, Columbus, chairman of the board. They are: Dr. Jonathan Forman, Columbus; Dr. J. Howard Holmes, Toledo; Dr. Paul Hoxsworth, Cincinnati; Dr. C. Edgar Northrup, Marietta; and Dr. John E. Rauschkolb, Cleveland.

Ex officio members of the board are: Dr. N. L. Burrell, Springfield; Dr. Robert C. Austin, Dayton; Dr. William M. Skipp, Youngstown; and Dr. Means.

SHOULD VITAMIN D BE GIVEN ONLY TO INFANTS?

VITAMIN D has been so successful in preventing rickets during infancy that there has been little emphasis on continuing its use after the second year.

But now a careful histologic study has been made which reveals a startlingly high incidence of rickets in children 2 to 14 years old. Follis, Jackson, Eliot, and Park* report that postmortem examination of 230 children of this age group showed the total prevalence of rickets to be 46.5%.

Rachitic changes were present as late as the fourteenth year, and the incidence was higher among children dying from acute disease than in those dying of chronic disease.

The authors conclude, "We doubt if slight degrees of rickets, such as we found in many of our children, interfere with health and development, but our studies as a whole afford reason to prolong administration of vitamin D to the age limit of our study, the fourteenth year, and especially indicate the necessity to suspect and to take the necessary measures to guard against rickets in sick children."

*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

MEAD'S Oleum Percomorphum With Other Fish-Liver Oils and Viosterol is a potent source of vitamins A and D, which is well taken by older children because it can be given in small dosage or capsule form. This ease of administration favors continued year-round use, including periods of illness.

MEAD'S Oleum Percomorphum furnishes 60,000 vitamin A units and 8,500 vitamin D units per gram. Supplied in 10- and 50-cc. bottles; also available in bottles of 50 and 250 capsules. Ethically marketed.

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In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

HOW DO THE SERVICES IN YOUR COUNTY RATE?

Self appraisal is not an easy, often a distasteful, procedure whether it be done by individuals, groups, or communities. Nevertheless, it is good for the soul and stimulates progress.

Dr. N. E. Leyda, president of the Montgomery County Medical Society, infers this in his "President's Page" in the *Montgomery County Medical News*, in which he jots down some of the points made in a report of the Health and Hospital Survey being completed in Dayton. Without comment, Dr. Leyda offers these findings for the consideration of the doctors of the county:

1. Sanitary supervision of food handlers inadequate.
2. Reporting of communicable diseases not complete, especially by private physician.
3. Increased VD control necessary.
4. Joint Public Health Department for the entire county.
5. Reporting of immunization of children. (The members of our Society could do this to our office and publish a yearly report.)
6. Inadequate staff of medical personnel in the Public Health Department.
7. A lack of a coordinated program for the control of tuberculosis—coupled with a shortage of sanitarium beds.
8. An incomplete program for maternal and child health supervision; and for the registration and care of crippled children.
9. A lack of community programs for dental health and for alleviation of the problems of cancer and heart disease.
10. A lack of medical social service in all hospitals.
11. A serious shortage of hospital beds for all types of cases with little provision for early mental disease, and for chronic diseases. The majority of existing beds, including those for isolation, are in obsolete, non-fireproof buildings.
12. Absence of a complete outpatient service for early diagnosis and treatment of the medically indigent. This is interesting also in relation to training facilities for interns and residents.
13. A lack of a health department program of industrial hygiene.
14. Gaps in community services for mental hygiene, for nutrition, and for health education.
15. Establishment of a department of registrar of vital statistics where births, marriages, divorces, and death registration would be centralized.
16. Director of tuberculosis control appointed in the Department of Health with an over-all supervision of tuberculosis in the entire county.

Dr. Leyda emphasizes that the report commends the medical profession for the good work which it is doing, and points out that he listed the criticisms merely to show the need for work to be done.

How about an appraisal of your own community's medical, health, and hospital services? How are these jobs being done in your town and county?

It would be well for the physicians in every locality to take an inventory. Uncovering flaws and weaknesses is the first step toward developing improvements. What group is better equipped to take the initiative than the medical profession? Think it over.

TEAMWORK IN GETTING DOCTORS FOR RURAL AREAS

The Ohio Farmer offers farm folks some good advice on the subject of "country doctors", to wit:

"Lack of physicians in rural communities has been and still is a serious problem. But the chance of solution is improving. Doctors are coming back from the service and want a good community in which to live as well as to practice. Schools of medicine were not stripped of their students as were other colleges so young doctors are coming up.

"Many of these were born and raised on the farm and prefer a rural community. Reasons they have flocked to the cities were more lucrative practice and more modern hospitals. But if farm communities will give their doctors loyal support and provide them with hospital facilities there is no reason why they shouldn't come back. It's up to farm folks to make their communities attractive to doctors looking for a location.

"And when a good one shows up, keep him. Show him he's welcome and give him some business, even if it is just a physical check-up. We give our livestock and machinery periodical examinations and overhauls but too many of us wait until we can hardly drag before we go to the doctor. It is easier and costs less to keep you well than to get you well."

With the exception of the slight inaccuracy regarding the supply of medical students, the editorial states the case well. Fortunately, many rural communities are taking active steps to make their areas attractive to physicians. They deserve all the support which other groups can give them, including the medical profession through its local, state, and national societies. Also, fortunately, medical societies are cooperating. Lots of teamwork will be required to solve this problem.

Rural communities should encourage boys and girls from those areas to make medicine a

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DOSAGE: One ESTINYL Tablet of 0.05 mg. daily. In severe cases two and three tablets may be prescribed daily. Current practice is to administer ESTINYL for two weeks after which a rest period of a few days is allowed. Such cycles are repeated as long as required.

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career as they are the ones most likely to establish practice in small communities.

Medical schools should place greater emphasis on general practice and should offer courses which will give the student the broad and diversified training needed for practice in sparsely settled areas.

Rural communities should, as the editorial quoted above states, provide the facilities which the physician needs in his practice.

Medical societies should take the lead in coordinating all these activities and, with hospital officials, should actively cooperate with and assist the young practitioners as they hang out their shingles, thereby stimulating their initiative and bolstering their confidence.

A.M.A. TAKES ADVANCED STEP IN P. R.

Retention of Raymond Rich Associates as a public relations counsel and the employment of a full-time public relations man in the headquarters office at Chicago have been authorized by the Board of Trustees of the American Medical Association.

Those who have been advocating this for some time—perhaps too long a time—will be gratified to learn of the Board's action.

But—don't let this action mislead you. While a step in the right direction, the employment of public relations experts does not in any way relieve physicians, individually and collectively, of their responsibilities in that field.

For our part, we would rather have 180,000 physicians on the firing line, doing an everyday job of giving the folks the right answers to medical and health matters, than all the public relations men from coast to coast.

The job of the public relations expert is to manufacture the ammunition and suggest how it is to be fired. The job of the medical profession is to supervise the manufacturing job and to do the firing of the finished product. The fellow in the ranks is still the indispensable man.

DECENTRALIZATION STRESSED IN NEW BOOK; READ IT

The case for decentralization of our economic and social life as a means to a happier, healthier life—a salvation for millions of Americans—is presented in an able and interesting manner in "Cities Are Abnormal", edited by Elmer T. Peterson, associate editor of *The Daily Oklahoman* and *The Oklahoma City Times*, formerly editor of *Better Homes and Gardens*, and published by the University of Oklahoma Press.

Four Ohioans have contributed chapters to this stirring appeal for the development of smaller communities between the great cities where there can be a more intimate connection between the production of raw materials and their manufacture and distribution; a better balance between industry and agriculture; the achievement of values and stability which an urban-congested industrialism has not been able to develop.

Dr. Jonathan Forman, editor of *The Ohio State Medical Journal*, author of the chapter on "Biological Truths and Public Health", stresses the point that "the task of getting our citizenry out of the restricting influence of city life, with its undue numbers of mental breakdowns and cases of insanity, its increased mortality, and its diminishing birth rate, demands immediate attention". Through a combination of urban and rural life, a manner of living will develop, states Dr. Forman, which "will bring genuine independence" and "will provide fresh air, light, sunshine, fresh nutritious food, real security against unemployment and old age, a greatly elevated standard of living, freedom from disease, dynamic health, and a busy, happy life for every member of the family".

Other Buckeye contributors are Louis Bromfield, author and farm manager; Paul B. Sears, professor of botany, Otterbein College; and Warren S. Thompson, director, Scripps Foundation for Research in Population Problems, Miami University, Oxford.

This volume is "must" reading, especially for those who are, or should be, concerned with finding solutions for the economic, social, and health problems which are confronting the nation. Surely, the physician is, or should be, so we suggest he put "Cities Are Abnormal" on his reading agenda for consumption at an early date.

—C.S.N.

DO YOU OR DON'T YOU? IF NOT—WHY?

The following article from the *Alameda County* (Calif.) *Medical Society Bulletin* has been reprinted in many medical journals. Perhaps you have read it. Nevertheless, reading it a second time won't hurt anyone, since it contains so much common, ordinary horse sense. As we have said before, each physician is the best public relations man at the command of the medical profession.

Wrote the Alameda County Society editor under the heading, "Public Relations Check List for Physicians":

Do I bill my patients regularly so they can plan and adjust their personal finances to meet the cost of medical care?

Do I send my delinquent accounts to a collector who will extract my fee regardless of the reasons for the delinquency or of the consequences to my patient?

In setting my fee, do I make any effort to learn of the patient's other current medical, dental, and hospital expenses for his family so that my charge is based upon the relation of



This famous prescription symbol, generally believed to be derived from the Latin "recipe" —take . . . is reputed to have been originally the symbol of Jupiter. This symbol was placed at the top of a formula to propitiate the king of gods in order that the compound might act favorably.

Almost as famous, but rooted purely in science, is the 43-year-old Rexall symbol of dependable drug service—displayed in selected and conveniently located pharmacies throughout the nation. It is a sign that fine Rexall drugs and expert pharmacy are at your service.

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the entire medical expense to the patient's ability to pay?

Am I giving each individual patient the best medical care and service of which I am capable?

Am I trying to crowd too many people into too short a time to permit me to practice good medicine?

Am I sufficiently willing to admit my limitations as to time and training and refer my patients to qualified physicians in my own or other fields when necessary?

Are my charges absolutely fair and commensurate with the work performed?

Do I discuss my charges frankly with my patient at the time, or before the work is done? Do I invite discussion as to his ability to meet those charges?

Do I adjust my charges on an emotional basis or on that of a competent investigation of the patient's ability to pay?

Do I instruct my patients on the benefits of hospital and health insurance?

Do I consider my patient's time as important to him as mine is to me and so plan my schedule that he is not kept waiting for an unreasonable period?

Do I respect my patient's faith in my integrity by having him return for subsequent treatments only when necessary?

Have I done everything possible from my standpoint to create a feeling of satisfaction in my patient as a result of this relationship with me?

ORGANIZATIONS, PROMOTERS AND EMOTIONAL APPEALS

Establishment of one national organization to direct a unified campaign for voluntary public health agencies, to approve their budgets and allocate funds, has been recommended in a report of the solicitations committee of the Cleveland Chamber of Commerce.

According to *The Cleveland News:*

The committee, headed by George F. Buehler and working under the guidance of Randall M. Ruhlman, manager of the Chamber's solicitations department, viewed the multiplicity of "drives" against particular diseases as a threat to the operation of community chests which raise funds for their own day-to-day welfare needs.

Issued on the eve of Cleveland's annual Community Fund campaign, the report expressed "concern and alarm at the growing tendency the creation of private organizations to promote the public health by specializing in the prevention and cure of particular diseases".

In the last year, the report said, Chamber of Commerce members have been solicited by national and local agencies specializing in tuberculosis, cancer, heart ailments, blindness, deafness, diabetes, leprosy, epilepsy, infantile paralysis, social diseases, and numerous allergies.

The committee made it clear that it did not "minimize the results accomplished nor weigh the value of one organization against another". But, the report continued, the monetary results from public appeals by voluntary agencies "is not in direct proportion to existing needs but is rather based on the efficiency of the fund-raising campaign".

The report charged that organizations "with a strong emotional appeal and which dramatize their campaigns amass reserves seemingly out of proportion to probable needs".

Some may disagree with the solution suggested by the Cleveland Chamber of Commerce. Few, however, will deny that a situation which needs a lot of study, exists.

Unless some solution is found, the public will react against all such organizations—the good as well as the questionable.

Although slightly aside from the point, the same applies to medical organizations. There are too many—some of them the brain child of promoters—trying to do jobs which have been done and are still being done by long-established medical groups—and done well.

What the country needs is not a good five-cent cigar but fewer organizations (including medical organizations) and more support for those organizations which have proved their worth over a long period of time.

LEADERSHIP IN FITNESS PROGRAM TAKEN BY A.M.A.

During World War II the United States Government and the American Medical Association had a Joint Committee on Physical Fitness. With the end of the war the government withdrew and the American Medical Association representatives thereafter constituted an Association Committee on Physical Fitness. This committee requested the A.M.A. Bureau of Health Education to suggest plans by which the American Medical Association could contribute to the improvement of health and physical fitness in the postwar period.

The plan submitted by the Bureau, approved by the Board of Trustees, and included in the 1946 Bureau budget, called for the employment of two professional persons and necessary clerical help to conduct a program promoting fitness through cooperation with the nation's schools.

A physician, Dr. Dean F. Smiley, and a physical educator, Fred V. Hein, Ph.D., have been employed and added to the staff of the Bureau of Health Education.

Their duties will be to study health education and physical education in schools and the preparation of teachers for functioning in these fields. Information will be collected and a clearing house established on courses of study, materials, school health service programs, and physical education.

These consultants will be available in the field to study situations and participate in planning locally for the establishment or improvement of health programs. No attempt will be made to "sell" a hard and fast program. Efforts will be devoted to cooperative planning for the improvement of school programs leading to better health and fitness and the existence of these programs where they do not exist. The con-

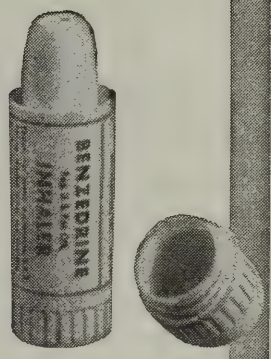
"Benzedrine Inhaler appears to eliminate the pain and discomfort which children associate with 'nose drops'... It can be administered with ease even to infants."

Scarano, J. A., and Coppolino, J. F.:Arch. Pediat. 54:97

Widespread pediatric acceptance

Children accept treatment with Benzedrine Inhaler, N. N. R., willingly, often with eagerness, and show none of the hostility which so often complicates treatment with drops, tampons, or sprays. The Inhaler, furthermore, produces a shrinkage of the nasal mucosa equal to, or greater than, that produced by ephedrine.

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sultants will work in close cooperation with the Joint Committee on Health Problems in Education which the National Education Association and the American Medical Association have long maintained. Their services will be available to state and local medical societies by correspondence or field trips.

The entire plan is based on the theory that better health and greater fitness for the nation can be achieved through the nation's schools.

The A.M.A. is to be congratulated for having established this long-overdue set up. School authorities, including physical educators, are initiating health and physical fitness programs in many communities—here in Ohio and elsewhere. Medical guidance is essential. We believe it will be welcomed. It must be given at local, state, and national levels.

The program boils down to real cooperation on the part of school authorities and members of the medical profession at all three levels. Through national guidance, state and local medical societies can function more efficiently. If the medical profession will assume leadership at state and local levels, the program nationwide can be made to click along sound, constructive lines.

IMPLICATION OF MINERS' MEDICAL FUND

Commenting on future relations between labor unions, employers, and the government, the *United States News* predicts: "Health and welfare fund, won by coal miners, will be asked by other groups."

The present agreement between the United Mine Workers and the Government provides for two funds. One, a welfare and retirement fund, created by a five cent per ton impost on every ton of coal produced, will be administered by three trustees, one appointed by the Coal Administrator, one by the union, and one to be agreed upon by the Coal Administrator and John L. Lewis. The second, a medical and hospital fund, will be built up by a checkoff from miners' pay and will be administered by three trustees appointed by the president of the United Mine Workers.

What will be the effect of this new phase injected into the whole question of expansion of medical and health service on the drive of the present Federal administration for a National Health Program? What will be its effect on the relationship between physicians and employers? With unions?

The significance of this innovation is obvious. It must not be underestimated.

It is assumed that the United Mine Workers —any other union which may acquire the same responsibility—will wish to see the medical and hospital fund administered fairly so as to insure receipt of the best of medical attention by all beneficiaries. If that is true, it is hoped that union leaders will seek the advice of competent medical authorities on medical as well as administrative questions involved. The principles and policies which insure good medical services are fundamental and universal, applying to any type of program irrespective of sponsorship.

VALUABLE REPORT ON HOSPITAL PLANNING AND BUILDING

According to a recent announcement from the Commission on Hospital Care, the commission has completed its study and is summarizing its findings.

The report, it is stated, will focus attention on the general hospital. The report will be published by the Commonwealth Fund, Division of Publications, 41 East 57th Street, New York 22, N. Y. It is anticipated that copies will be available for distribution early in 1947. Hospital functions, use and location, measuring need, integration, etc., are some of the vital subjects which will be covered in the report.

Recent enactment of Federal legislation providing funds for hospital surveys and construction has heightened interest in this question throughout all the states. Ohio physicians and others in this state should possess a copy of this study. Those interested should place their order at once with the Commonwealth Fund. It undoubtedly will have much valuable data which can be used as a guide for those planning the expansion of hospital capacities, planning the building of new hospitals, and planning improvement in hospital administration.

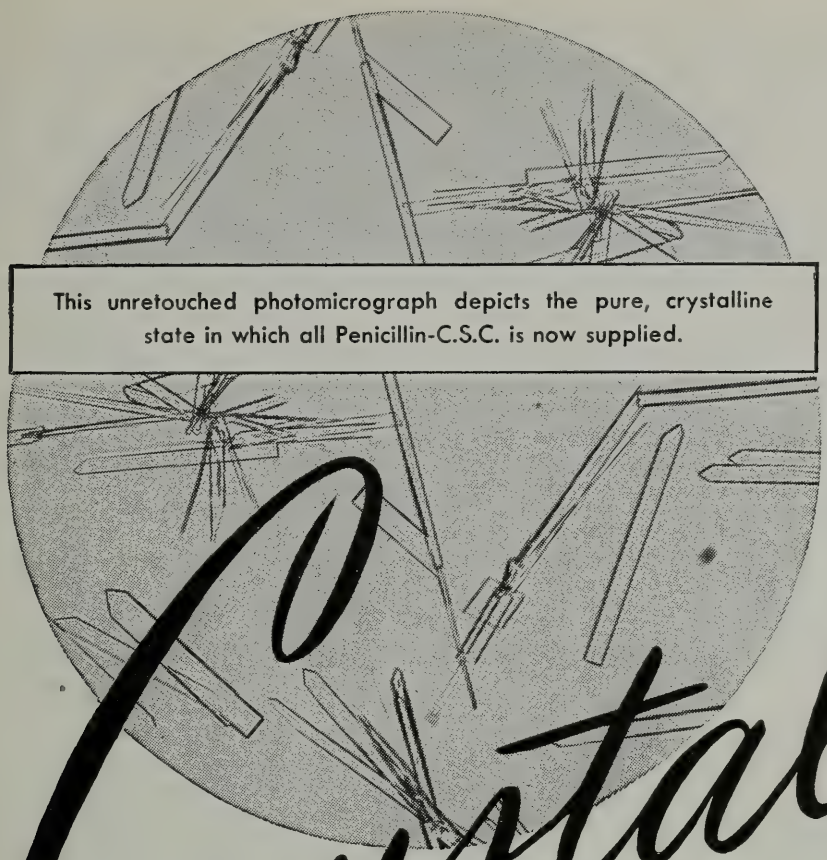
Building hospitals or enlarging existing hospitals is serious business—big business. The advice of experts should be sought to avoid and minimize mistakes.

TIME FOR DECISION GROWING SHORT

"The leading executive or political leader who wants private enterprise in business but who is willing to tolerate the regimentation of medicine, of public health, and of voluntary social effort is toying with the camel whose nose is already in the tent", comments Dr. D. B. Armstrong in his stimulating article, "Facts and Fallacies in the Integration of National Voluntary Health Agencies", published in the June 15 issue of *The Journal of the A.M.A.*

Some of the business men in your community undoubtedly qualify for the above classification. They don't give a hang about the voluntary health programs which interested physicians and laymen are plugging. "Let the government do it", they say. "Why should I contribute; I'm paying plenty of taxes", they answer.

But, by the same token they want government



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Crystalline Penicillin Sodium-C.S.C. is available in serum-type vials containing 100,000, 200,000, or 500,000 units.

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to keep its nose out of business, especially their business.

There are but two alternatives. On one hand, well-financed, properly supervised, voluntary, community organizations doing the jobs which volunteer civic-minded individuals can do. On the other, politically-controlled, governmental agencies which are hankering to gobble up the whole field.

Because of the vital principles involved, it is time for business and professional people to decide which course they want to follow; time for them to realize they can't have their cake and eat it.

With all their weaknesses, mistakes, and, let us say, "politics", the voluntary organizations are a far cry from statism which can not be avoided when everything is turned over to the "official" agency and the bills are met through tax-levying devices.

EMOTIONAL AND MENTAL PROBLEMS WILL BE STUDIED

More medical schools should follow the pattern which is being drafted by Western Reserve University School of Medicine which has announced that first-year students will be introduced to the emotional and mental problems of patients.

According to Dr. Douglas D. Bond, recently appointed professor of psychiatry, they will learn the difference between behavior of normal persons afflicted with injury or illness and that of patients who are emotionally or mentally abnormal.

Emphasis upon emotional and mental disturbances is in line with the growing tendency among schools of medicine to teach their students to treat the patient as well as the disease.

In outlining the program to prescribe larger doses of psychiatric training for its students, Dr. Bond said, "It is generally observed that about half the people who seek medical care have some emotional or mental disturbance." He added:

"In order to prescribe effective treatment for most any illness, physicians must take this into consideration. Even a normal person who is ill has some emotional disturbance. No one can be sick without being worried. Emotional disturbances, on the other hand, frequently lead to serious illness. Everybody knows this, and yet little has been done about it, for physicians have not given sufficient recognition to the part emotions play in disease."

During the four years of study at the School of Medicine, there will be an increased emphasis upon psychiatry, Dr. Bond said, so that when the graduate goes into practice he will know how to recognize, evaluate, and treat mental and emotional abnormalities of his patients.

LADY COLUMNIST LETS DOWN HER HAIR

Letting down her hair, the writer of "A Woman's Point of View" column appearing in an Ohio newspaper takes a swing at the doctors on the subject of "Night Calls". Quoting:

"Once before I had occasion to call attention to the fact that our more prosperous doctors do not make night calls. At the time I cited the cause as being due to war-time shortage of physicians. But now that the war is over, this matter comes up again for discussion.

"Doctors in general practice are supposed to make night calls as a matter of service to their patients. When doctors assume the policy that no matter what the emergency, they will not do so, they are taking advantage of these people from whom they earn their living.

"There is a growing trend among our doctors not to make night calls. They evidently assume that they will get the business anyway the next day, and so, why worry if the patient suffers during the night. The trend has reached the place where some doctors take their phones off the hook, or won't even give advice over the telephone.

"There is a reason for all of this. Among our folk the medical doctor represents the cream of society. He gets all sorts of invitations to attend civic and social affairs. If he has a wife who loves these sort of things, he is kept pretty busy keeping up with the Joneses.

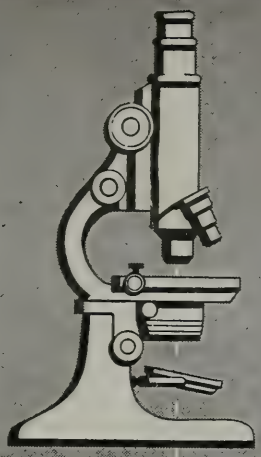
"Other doctors like to play cards and there has been many a hurried call ignored by them while they were in the process of losing. They say that doctors don't mind leaving when they are ahead of the game. I really don't know why this is.

"It is high time that the patients make a few demands on doctors about this no-night call business, since it is in the early hours of the morning that the medical profession has rendered the greatest human service to those on the brink of death. For doctors who become too prosperous to serve their patients don't need their business."

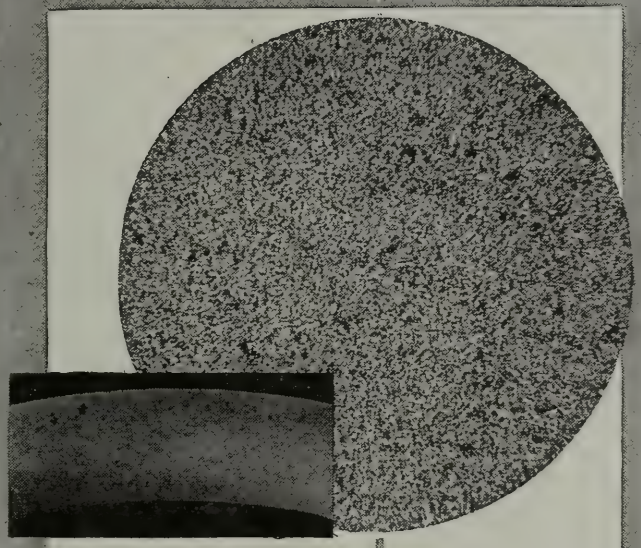
We wouldn't know anything about "keeping up with the Joneses" or about the docs running out on a card game. We do know, however, that it's none too pleasant to crawl out of bed to make unnecessary calls and we doubt if most physicians are quite as high-hat as the above leads one to believe.

Nevertheless, the lady's thesis can't be totally ignored. A few of the boys have gotten to be a little too independent, or let us say, a little undiplomatic, in the way they deal with some of their patients. Whether he likes it, or realizes it, the doctor is regarded by the community in a different light than the average dispenser of materials and services. He is something mighty important to the sick person and his family.

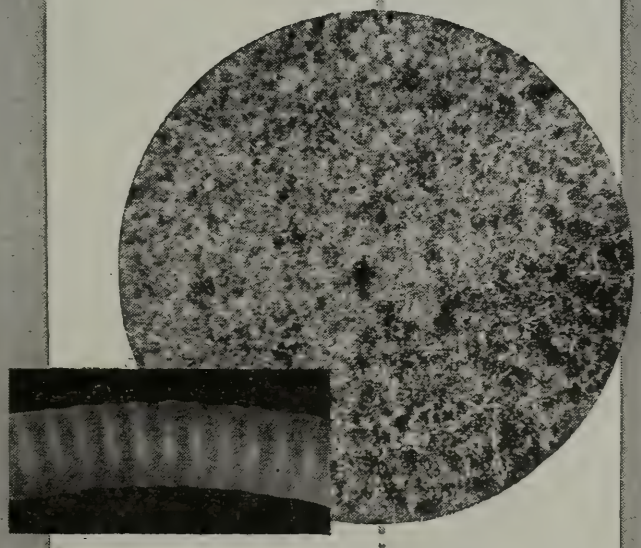
To maintain his prestige and retain the faith of his patients, he has to take the bitter with the sweet—at least he should. The doctor has his side of the story also, but in the final analysis, a few sacrifices now and then will yield him real dividends in the form of proper public relations and continued devotion from the people of his community.



Through the MICROSCOPE



No. 1 Unretouched photomicrograph of the dome (enlarged 10 diameters) and the rim (inset) of a "RAMSES" Flexible Cushioned Diaphragm.



No. 2 Unretouched photomicrograph of the dome (enlarged 10 diameters) and the rim (inset) of a conventional-type diaphragm.

quality first since 1883

The discerning eye of the microscope reveals notable advantages of the "RAMSES"* Flexible Cushioned Diaphragm.

Only the "RAMSES" has the patented rim construction which provides both a wide, unindented area of contact with the vaginal walls, and a cushion of soft rubber to buffer spring pressure.

The pure gum rubber used in the dome is prepared by an exclusive process which imparts lightness, strength, velvet smoothness, and long life.

Ramses
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ACCEPTED AMERICAN MEDICAL ASSN Council on Pharmacy and Chemistry

FLEXIBLE CUSHIONED DIAPHRAGM

Manufactured in gradations of 5 millimeters in sizes ranging from 50 to 95 millimeters, inclusive. Available through all recognized pharmacies.

Ramses — TRADE MARK REG. U.S. PAT. OFF. — DEPENDABILITY

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*The word "RAMSES" is a registered trademark of Julius Schmid, Inc.

VETERANS' INQUIRY DEPARTMENT

Ohio Openings and Locations Sought by Returning Medical Officers; Opportunities Available Listed

THE purpose of this department is to provide space without cost to Ohio veteran physicians for the publication of inquiries they may wish to make concerning an assistantship or residency, a partnership or space in an office, locations and purchase of a practice, purchase of equipment, etc.

The new feature also offers an opportunity for physicians who desire to dispose of their practice or institutions and agencies needing staff physicians to publicize this information for the benefit of service men.

The feature will appear monthly as long as there seems to be a need for it. The regulations governing it are: (1) The veteran submitting the inquiry must be an Ohio physician, i.e., one who was in practice in Ohio when he entered the service or was a native of Ohio but still in training when he entered in the service. (2) Inquiries should not exceed 35 words. (3) Copy must be submitted by the 20th day of the month preceding date of publication. (4) Unless otherwise specified, each inquiry will be carried in two consecutive issues of *The Journal* but no oftener. (5) *The Journal* reserves the right to reject or edit copy submitted; also, to eliminate the new department when and if conditions warrant. (6) Inquiries should be accompanied by full name, forwarding address and identifying data.

OPPORTUNITIES SOUGHT

LOCUM TENENS DESIRED: Wanted for three months beginning September 15 by Navy medical officer who will begin residency January 1. Graduate of Harvard Medical School in 1944; aged 26; internship Lakeside Hospital, Cleveland. V.I.D. No. 22.

SEEKS INDUSTRIAL ARRANGEMENT: Veteran with extensive industrial background seeks association with individual or group in this type of practice. Willing to invest. Cleveland area preferred but others also considered. V. I. D. No. 23, care of Ohio State Medical Journal.

ASSISTANTSHIP WANTED: Assistantship to general practitioner or radiologist sought by naval officer to be discharged September 1. Age 28. Ohio license. Graduate of Cincinnati University College of Medicine. Rotating internship. Two and one-half years part-time civilian and two years Navy roentgenology. V.I.D. No. 24.

ASSOCIATION DESIRED: Veteran desires position with small medical group or assistantship with pediatrician or general practitioner in town over 20,000. Ultimate desire is to specialize in pediatrics. V.I.D. No. 26.

ASSISTANTSHIP WANTED: Surgeon, aged 32, Army experience and eligible to American Board of Surgery, available in Fall of 1946, desires assistantship to older surgeon, group practice, association with internist, etc. Experience in general surgery, neurosurgery, orthopedic surgery; Ohio license. V.I.D. No. 27.

WANTS ASSOCIATION WITH GROUP OR SPECIALIST: Army veteran, aged 31, married. Ohio State University graduate, Ohio license, eligible to American boards in obstetrics and gynecology, desires position with group clinic or established specialist. Spent 21 months in ETO in general surgery and ob-gyn. V.I.D. No. 29.

SEEKING ASSISTANTSHIP: Army veteran desires assistantship with general practitioner, with possible future partnership. Ohio State University graduate in 1943; rotating internship; aged 30; single. V.I.D. No. 30.

ASSOCIATESHIP, GROUP OR SPECIALIST SOUGHT: Veteran with qualifications for certification by American Board of Internal Medicine, aged 30, graduate of Ohio State University, desires association with group or with board member—preferably with university affiliations. Have had research and teaching experience. V.I.D. No. 31.

LOCUM TENENS SOUGHT: By graduate of Medical College of Virginia, 1939. Also, interested in assistantship in general practice, internal medicine, or pediatrics, beginning in October. Will enter residency University Hospitals, Cleveland, July, 1947. V.I.D. No. 32.

ASSOCIATION SOUGHT: Internist, completing three-year residency in internal medicine, January 1, 1947, interested in association with surgeon, with group or in part-time industrial practice. City of 15,000 or more population desired. V.I.D. No. 33.

LOCUM TENENS: Navy veteran wishes locum tenens or assistantship to general practitioner in Columbus or near vicinity until January 1, 1947. Have residency in medicine starting that date. Graduate, Ohio State University College of Medicine; internship at Los Angeles County General Hospital. V.I.D. No. 34.

ASSISTANTSHIP REQUESTED: Veteran, aged 35, Ohio license in 1935, desires assistantship with proctologist, starting July 1, 1947. Rotating internship, six years general practice, two years proctology in Army hospital, completing 18 months surgery residency. V.I.D. No. 35.

ASSISTANTSHIP OR PRACTICE DESIRED: Young, recently-discharged medical officer wants assistantship, partnership or established general practice in Northern or Central Ohio. Graduate of Ohio State University. Internship and 9-months residency in internal medicine completed. V.I.D. No. 36.

OPPORTUNITIES OFFERED

ASSOCIATION WITH SURGEONS: Opening for young man, not interested in surgery, who would like to be associated in practice with two well-established surgeons. Compensation on percentage of gross income to the practice, depending upon training and personal qualifications. Part-time residence could be obtained in a small general hospital at substantial salary while a practice is being built. Industrial town of 15,000 population, Northeastern Ohio. All equipment and supplies furnished. Write H.R.A., care of Ohio State Medical Journal.

OPENING FOR ANESTHETIST: Diplomate of Board of Anesthesiology or fellow of American Society of Anesthesiology wanted as an associate or to practice independently as a full-time anesthetist. Write Fred W. Brosius, M.D., Middletown, Ohio.

PRACTICE AVAILABLE: General practice in DeGraff available. No property to sell. Forced to retire because of health. Good field for lively young physician. Write O. W. Loffer, M.D., DeGraff.

INTERNS AND HOUSEMEN NEEDED: Good Samaritan Hospital, Dayton, has openings for six interns. Internships approved by American Medical Association. Weekly seminars offered by members of various specialty boards. Also vacancies for four returning veterans as housemen; also entitled to seminars. Stipends for interns $50.00 with full maintenance; stipends for housemen, $150.00 with full maintenance. Contact Intern Committee of hospital.

(Continued on page 1078)



WELL TOLERATED by the NEWBORN

Clinical experience establishes that CARTOSE* is especially well tolerated by newborn infants.

CARTOSE supplies carefully balanced amounts of non-fermentable dextrins, with maltose and dextrose. These offer the advantages of: spaced absorption because of the time required for hydrolysis of the higher sugars ; less likelihood of distress due to the presence of excessive amounts of fermentable sugars in the intestinal tract at one time.

CARTOSE is liquid; formula preparation is simple, rapid, and accurate. It is compatible with any formula base: fluid, evaporated, or dried milk.

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Mixed Carbohydrates

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PRIVATE INDUSTRIAL PRACTICE: Good opportunity for young physician who wishes to engage in private industrial practice in industrial center. Physician now handling work changing locations. If interested, write T.H.L. care of Ohio State Medical Journal.

PART-TIME INDUSTRIAL PRACTICE: Good opening for physician interested in part-time industrial practice, physical examinations, and emergencies. Columbus industrial firm. Write C.W.C., care of the Ohio State Medical Journal.

ASSISTANTSHIP TO G.P.: Assistantship to busy general practitioner in large Northwestern Ohio city available; modern office. Percentage basis should average at least $5,000-$6,000 first year; partnership possible, later. Box Z, care of Ohio State Medical Journal.

LOCATION FOR GENERAL PRACTICE: Opening for general practice in town of 3,500 on Ohio River. Office space available. Shortage of active physicians at present. Box S, care of Ohio State Medical Journal.

INDUSTRIAL COMMISSION: Openings available in Medical Section, Ohio Industrial Commission. Consult Dr. Robert André, chief supervisor, Medical Section, State Office Bldg., Columbus.

STATE HOSPITAL STAFF OPENINGS: Staff physicians for various institutions serving the mentally ill, mentally defective and epileptic needed. Physicians who have had some psychiatric training or experience preferred but can offer positions to doctors who may be interested in becoming acquainted with the specialty. A position of special importance now open is: Clinical Directorship, Gallipolis State Institute (fine opportunity for man who has had neuropsychiatric training to become acquainted with those neurological conditions that cause epilepsy in addition to a chance to be a specialist in the field of true epilepsy). Consult Dr. Frank F. Tallman, Ohio Commissioner of Mental Hygiene, State Departments Building, Columbus 15.

PUBLIC HEALTH OFFICERS NEEDED: Several counties in Ohio in need of full-time health commissioners. Those with training and experience, or interested in public health work, may obtain complete details from Dr. Roger Heering, Ohio Director of Health, State Departments Building, Columbus 15.

PRACTICE FOR SALE: Active practice in a community of 3,000, North Central Ohio. Large amount of industrial work in addition to regular practice. Equipment includes new X-ray, diathermy, modern furniture, drugs and supplies. No real estate for sale. Moderate rent. Estimated price $7,500, cash or terms. Will introduce for a short time. Write R.J.S., care of Ohio State Medical Journal.

VETERANS ADMINISTRATION: Openings for physicians as members of rating boards for either full time or part time duty. Basic salary $4300.00 per annum, with additional compensation for overtime. Contact nearest V.A. office for particulars.

FULL-TIME RESIDENT PHYSICIAN NEEDED: At Homeplace, Perry County, Kentucky, operated by E. O. Robinson Mountain Fund as educational center for mountain people. Graduate nurse; clinic building being planned; affiliation with medical center in Cincinnati for consultation and specialized services; salary $5,000 per year, with home and transportation furnished. Write Dr. Howard P. Fischbach, 1122 Carew Tower, Cincinnati 2, Ohio.

PRACTICE AND HOME FOR SALE: Active practice established 10 years in town of 2000 with local post office serving 8000. Brick and stone home with modern interior. Has suite of rooms for office. All modern office equipment with stock of drugs and X-ray, diathermy, ultraviolet. Seeing more than 20 patients per day. Physician urgently needed. Forced by service-connected disability to retire from general practice. All is offered to a veteran for price of real estate alone. Liberal terms; can pay for all in three years from earnings. M. R. Wedemeyer, M.D., Oak Hill, Ohio.

HOSPITAL OPENING: Summit County Receiving Hospital, recently opened by welfare department, in need of assistant physician psychiatrist to do work of physician on military leave. Man under 35 years of age with residency in psychiatry preferred. Pay, $275.00 per month in addition to maintenance for self and family. Hospital also needs graduate nurses to complete staff, pay scale $163.00 for general floor duty to $196.00 for supervisory duty and Instructor, R. N. and a Director of Nurses, R. N. with baccalaureate degree. Write Summit County Receiving Hospital, Cuyahoga Falls, Ohio.

INDUSTRIAL POSITION: Wanted, physician between ages 30-40 interested in a career in industrial medicine. Some experience in surgery required. To have charge of medical department. Salary to start, $7,500.00-$8,000.00. Needed immediately. Opportunity for advancement. Large manufacturing firm in Northern Ohio. State age, education and experience. Box 200, care of Ohio State Medical Journal.

MEDICAL DIRECTOR SOUGHT: Full-time medical director for new Ohio division of large national industry located in Northern Ohio. Well-equipped medical department. Want man with some industrial experience; ability and personality to promote public relations in this type of work. Box 300, care of Ohio State Medical Journal.

Dr. Brady Is Elected President of N.W.O. Medical Association

Dr. E. L. Brady, Marion, was elected president of the Northwestern Ohio Medical Association during its 102nd meeting, which was held October 1 at the Shawhan Hotel and Tiffin Theater in Tiffin. He succeeds Dr. John M. Lehay, Tiffin.

Dr. Robert J. Semons, Carey, was re-elected as vice-president, and Dr. W. W. Green, Toledo, was again chosen as secretary. Dr. R. E. Rasor, Bloomdale, was elected to succeed Dr. Brady in the office of treasurer.

Dr. J. Craig Bowman, Upper Sandusky, will serve as Councilor for the Third District and Dr. A. A. Brindley, Toledo, the Fourth District. Local arrangements were in charge of Dr. R. F. Machamer, Tiffin. Marion, Ohio, was chosen as the location of the 103rd meeting.

After the business meeting, the following papers were presented:

"Chronic Intestinal Diseases in Children", Dr. Philip Howard, associate of pediatrics, Henry Ford Hospital, Detroit; "Early Ambulation After Operation", Dr. Daniel J. Leithauser, chief surgeon, St. Joseph's Mercy Hospital, Detroit.

"Psychosomatic Medicine in Gynecology and Obstetrics", Dr. Jean P. Pratt, head of gynecology and obstetrics, Henry Ford Hospital, and "Coronary Disease", Dr. F. J. Smith, head of cardiology and respiratory diseases, Henry Ford Hospital.

The luncheon speaker was Jay Ketchum, executive director of Michigan Medical Service. He discussed the subject "Voluntary Prepaid Medical Care".

A.M.A. Accepting Applications for Annual Scientific Exhibits

Application forms for space in the scientific exhibit of the centennial session of the American Medical Association, to be held June 9 to 13, 1947, in Atlantic City, are now available, according to Thomas G. Hull, Ph.D., A.M.A. director of scientific exhibits.

The centennial display will include both the history of medicine during the past century, and the latest developments of medical science.

Exhibitors must apply for space on the regularly prescribed form by January 13, 1947, after which date the exhibit committee will make its decisions. The blank forms may be secured from Dr. Hull, whose address is the American Medical Association, 535 North Dearborn Street, Chicago 10.

112 diagnostic *Allergens*



FOOD ALLERGENS

Almond
Apple
Apricot
Asparagus
Banana
Barley
Bean
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Beet
Brazil Nut
Broccoli
Buckwheat
Cabbage
Cantaloupe
Carrot
Cauliflower
Celery
Cheese, American
Cheese, Swiss
Cherry
Chicken
Clam, Hard
Cocoa
Cocoanut
Codfish
Coffee
Corn
Crab
Cucumber
Duck
Eggwhite
Eggyolk
Flounder
Gelatin
Ginger
Grape (Raisin)
Grapefruit
Halibut
Herring
Honeydew
Lactalbumin
Lamb
Lettuce
Lima Bean
Lobster
Mackerel
Milk (Cow)
Mushroom
Mustard
Oat
Onion
Orange
Oyster
Pea
Peanut
Pecan
Pepper (Red, Green)
Perch
Pike
Pineapple
Pork
Potato
Prune (Plum)
Pumpkin
Quince Seed
Radish
Rice
Rye
Salmon
Sardine
Scallop
Shrimp
Soy Bean
Spinach
Strawberry
Sweet Potato
Tomato
Tuna Fish
Veal
Walnut (English)
Wheat
Whitefish (Lake)
Yeast

INCIDENTAL ALLERGENS

Cotton Seed
Dust
Flaxseed
Glue
Gum Karaya
Kapok
Orris Root
Pyrethrum
Silk
Tobacco

EPIDERMAL ALLERGENS

Cat Hair
Cattle Hair
Dog Hair
Goat Hair
Feathers, mixed
Hog Hair
Horse Dander
Rabbit Hair
Sheep Wool

FUNGUS ALLERGENS

Alternaria sp.
Aspergillus fumigatus
Chaetomium sp.
Cladosporium
Epidermophyton inguinale
Hormodendron
Monilia sitophila
Mucor plumbeus
Penicillium digitatum
Trichophyton interdigitale

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THERE is increasing evidence that, in asthma, gastrointestinal allergies, infantile eczema, migraine, etc., treatment of allergic sensitivities is yielding gratifying results.

To facilitate diagnosis, Arlington offers a specially prepared assortment of 112 diagnostic allergens representing the most commonly reported causative factors . . . foods, epidermals, fungi and incidentals. Each vial contains sufficient material for at least 30 tests. Full instructions for the simple scratch-test technique and a supply of N/20 NaOH are included.

These dry allergens remain active indefinitely at room temperature. The allergens listed represent the standard Arlington selection. If preferred you may make your own selection of 112 allergens from our current list, available upon request.

$35.00 ALLERGY DIAGNOSTIC SET

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RETURN TO CIVILIAN LIFE AFTER MILITARY SERVICE

FOLLOWING are the names of additional Ohio physicians who have been released from military service or have started terminal leave, according to information received recently by *The Journal*. The rank shown is based on the most recent data in the files of the Ohio State Medical Association.

Name	City	Rank
Adams, Wendall W.	Cleveland	Lt. (j.g.), U.S.N.R.
Adelman, Louis	Columbus (formerly of Cleveland)	Capt., A.U.S.
Angerman, R. H.	Massillon	Lt. (j.g.), U.S.N.R.
Armour, Deane B.	Bradford (formerly of Dayton)	Capt., A.U.S.
Ashe, William F., Jr.	Cincinnati	Lt. Col., A.U.S.
Beale, Charles C.	Mt. Sterling	Capt., A.U.S.
Bell, Paul L.	Toledo	Capt., A.U.S.
Bolotin, Joseph H.	Cleveland	Capt., A.U.S.
Booth, Edmond J.	Newcomerstown	Capt., A.U.S.
Bortz, Donald W.	Cleveland	Lt. (j.g.), U.S.N.R.
Boyer, Francis C.	Cleveland	Asst. Surg., U.S.P.H.S.
Broh-Kahn, Robert H.	Cincinnati	Lt. Col., A.U.S.
Brooks, Richard H.	Columbus (formerly of Huntsville)	Capt., A.U.S.
Browne, Edward W.	Greenville (formerly of Dayton)	Capt., A.U.S.
Bucher, Louis F.	Dayton	1st Lt., A.U.S.
Campbell, George W.	Los Angeles, Calif. (formerly of Columbus)	Major, A.U.S.
Campbell, Samuel J.	Bucyrus	Major, A.U.S.
Crouch, Corbin L.	East Sparta (formerly of Akron)	Lt. Col., A.U.S.
Cunningham, James K.	Newark (formerly of Cincinnati)	Lt. Comdr., U.S.N.R.
D'Amore, A. R.	Washington, D.C. (formerly of Youngstown)	Capt., A.U.S.
Dehn, Helmut M.	Cleveland	1st Lt., A.U.S.
Detesco, Andrew A.	Youngtown	Lt., U.S.N.R.
Devanney, John W., Jr.	Cincinnati	Major, A.U.S.
Dewald, Donald W.	Mansfield (formerly of Cleveland)	Major, A.U.S.
Elliott, Harold B.	Springfield	Capt., A.U.S.
Felson, Henry	Cincinnati	Lt. Col., A.U.S.
Feltes, E. J.	Cleveland	Capt., A.U.S.
Flagge, Albert E.	Cincinnati	Capt., A.U.S.
Flynn, William J.	Youngstown (formerly of Cleveland)	Major, A.U.S.
Fox, Thomas E.	Columbus	Major, A.U.S.
Freedman, Eugene	Los Angeles, Calif. (formerly of Cleveland)	Lt. Col., A.U.S.
Froug, Charles	Dayton	Capt., A.U.S.
George, Walter L.	Willoughby	Major, A.U.S.
Goldcamp, Joseph H.	Cincinnati (formerly of Ironton)	Lt., U.S.N.R.
Haskin, Grace	Cleveland	Lt. Comdr., U.S.N.R.
Haufrect, Fred	Houston, Texas (formerly of Cleveland Heights)	Major, A.U.S.
Hertz, Harold J.	Cleveland	Capt., A.U.S.
Jasper, Omer J.	Cincinnati	Major, A.U.S.
Johnston, Charles E.	Columbus (formerly of Cincinnati)	Capt., A.U.S.
Kayser, Frederick W.	Toledo	Capt., A.U.S.
Keller, Karl W.	Canton	Major, A.U.S.
Kezur, Edward	Cincinnati	Capt., A.U.S.
Kiefer, Charles F.	Cincinnati	Capt., A.U.S.
Klein, Harold C.	Cleveland	Capt., A.U.S.
Krichbaum, Franklin M.	Canton	Lt., U.S.N.R.
Kuhn, Howard F.	Cincinnati	Lt., U.S.N.R.
Landes, John S.	St. Louis, Mo. (formerly of Cleveland)	1st Lt., A.U.S.
Light, Richard C.	Cleveland (formerly of Lima)	Capt., A.U.S.
Loeb, Robert D.	Boston, Mass. (formerly of Columbus)	1st Lt., A.U.S.
Lotzoff, Harold A.	Lima	Capt., A.U.S.
Maczuga, John A.	Cleveland (formerly of Toledo)	Capt., A.U.S.
Martin, William J.	Fremont	Capt., A.U.S.
McCarthy, Justin E.	Cincinnati	Col., A.U.S.
McCoy, Francis W.	Columbus	Capt., A.U.S.
McNeal, Elmore R.	Cleveland	Lt. Comdr., U.S.N.R.
Meyer, Paul D.	Cincinnati (formerly of Cleveland)	Major, A.U.S.
Mincks, Charles B.	Cuyahoga Falls	Major, A.U.S.
Oppenheim, Heinz	Cleveland	Capt., A.U.S.
Oyer, Robert S.	Wapakoneta (formerly of Lima)	Capt., A.U.S.
Peal, Stanley	Baltimore, Md. (formerly of Cincinnati)	Major, A.U.S.
Perrine, George B.	Cincinnati	Lt. Comdr., U.S.N.R.
Perry, William H.	Cleveland	Capt., U.S.N.R.
Pichette, C. E.	Youngstown	Capt., A.U.S.
Puleo, Anthony M.	Cleveland	Lt. (j.g.), U.S.N.R.
Raines, James R.	Portland, Oregon (formerly of Cleveland)	Lt. Col., A.U.S.
Rath, Albert E.	San Antonio, Texas (formerly of Wooster)	Major, A.U.S.
Rogers, John A.	Youngstown	Capt., A.U.S.
Rossmiller, Harold	Cleveland	Major, A.U.S.
Roth, Dale E.	Newark	Major, A.U.S.
Rundell, Karl D.	Cleveland	Major, A.U.S.
Scherger, Frank E.	Delphos	Capt., A.U.S.
Schmitt, Clarence F.	Canton	Capt., A.U.S.
Schwinger, Aaron	Cincinnati	Capt., A.U.S.
Shapiro, Nathan	Cincinnati	Major, A.U.S.
Shehan, Thomas A.	Shaker Heights	Lt. Col., A.U.S.
Smith, Kenneth M.	Columbus	Lt. Col., A.U.S.
Speed, George W.	Dayton (formerly of St. Marys)	Lt. Col., A.U.S.
Sroufe, Douglas G.	Mt. Orab (formerly of Cincinnati)	Capt., A.U.S.
Stewart, James B.	Cleveland	Capt., A.U.S.
Strong, James C., Jr.	Denver, Colorado (formerly of Cincinnati)	Capt., A.U.S.
Thomas, James J.	Boston, Mass. (formerly of Alliance)	Capt., A.U.S.
Thompson, George O.	Alliance	Major, A.U.S.
Turek, Robert O.	Toledo (formerly of Cleveland)	Major, A.U.S.
Vernier, Paul C.	Stryker (formerly of Columbus)	Capt., A.U.S.
Ward, Harold W.	Columbus	Lt. Col., A.U.S.
Wendelken, Harold W.	Miami, Oklahoma (formerly of Kent)	Lt., U.S.N.R.
Wenner, Donald R.	Upper Sandusky	Lt. (j.g.), U.S.N.R.
Westbrook, E. R.	Warren	1st Lt., A.U.S.
Winter, Andrew A.	Toledo	Capt., A.U.S.
Young, Edward B.	Lima	1st Lt., A.U.S.
Zeligs, Meyer A.	San Francisco, Calif. (formerly of Cincinnati)	Comdr., U.S.N.R.
Zodikoff, Rudolph	Cincinnati	Major, A.U.S.
Zollinger, William K.	Toledo	Capt., A.U.S.

The September issue of *The Journal* listed Dr. Dudley M. Stewart, formerly of Toledo, as having been separated from the service with the rank of Major, and located at New Orleans, La. Information subsequently received reveals that Dr. Stewart attained the rank of Lieutenant Colonel, and has returned to practice in Toledo.

Gastroenterological Prize Contest

The National Gastroenterological Association has announced its annual cash prize award contest for 1947. One hundred dollars and a certificate of merit will be given for the best unpublished contribution on gastroenterology or allied subjects. Certificates will also be awarded those physicians whose contributions are deemed worthy.

All entries for the 1947 prize should be limited to 5,000 words, be typewritten in English, prepared in manuscript form, submitted in five copies, accompanied by an entry letter, and must be received not later than April 1, 1947. Entries should be addressed to the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

"Footprints on the sands of time"—No. 1

of a series honoring the contributions of eminent personalities of medicine and pharmacy.

JOHN MORGAN - 1735-1789

Physician and Pharmacist

Founder of the first medical school affiliated with any college or university in this country — the Medical School of the College of Philadelphia, now the Medical Department of the University of Pennsylvania.

In the first commencement address at the College he stated:

"We must regret that the very different employment of physician, surgeon and apothecary should be promiscuously followed by any one man. They certainly require very different talents.

*"The business of pharmacy is essentially different from either, free from the cares of both, the apothecary is to prepare and compound medicines as the physician shall direct . . ."**

His pioneering efforts in establishing the separation of functions of the physician and the pharmacist advanced their roles as guardians of the public health — the physician as diagnostician and prescriber, and the pharmacist as compounder and dispenser.



*LaWall, C. H.: Four Thousand Years of Pharmacy. An Outline History of Pharmacy and the Allied Sciences. Philadelphia, J. B. Lippincott Company, 1927; p. 403.

As manufacturing pharmacists, The Harrower Laboratory, Inc. recognizes its obligation to continue serving the interests of public health in cooperation with the physician and the dispensing pharmacist.

The Harrower Laboratory Inc.

GLENDALE 5, CALIFORNIA

Appeal to Physicians To Send in Questionnaires Now Is Made by Ohio Study of Child Health Services

THE Ohio Study of Child Health Services being carried on under the auspices of the American Academy of Pediatrics is entering the final stage in which the information that is being collected concerning the facilities and services for the medical care of children in the State will be handed over to the statisticians for tabulation and analysis.

In order to get a valid picture of the situation in Ohio, the Ohio Committee hopes to get as nearly 100 per cent return of questionnaires as possible. As of October 15 the return of physicians' schedules was 44 per cent; that of the dentists' schedules was 56 per cent.

An appeal to the physicians of the State to return their questionnaires to the Ohio Study is being made by the Committee. If any physician's name has not been included in the mailing list of the study he may obtain his questionnaire by writing to the Ohio Study of Child Health Services, Children's Hospital, Columbus 5, Ohio.

The following statement regarding the survey was prepared by E. V. Turner, M.D., executive secretary of the Ohio Study Committee:

REPORTS TO BE COMPILED

"The mass of information concerning medical services and facilities for children that is being collected by the Ohio Study of Child Health Services will form the basis of a number of reports which may be published in later issues of *The Ohio State Medical Journal*. The purpose and methods of the study undoubtedly are familiar to all Ohio physicians, as articles have appeared in recent issues of *The Journal*. After the information being gathered from physicians, dentists, hospitals, and health departments is complete it will be turned over to statisticians who will tabulate it and break it down by counties and by cities with a population of 10,000 and over. The Ohio Study Committee will then write a factual report of the findings of the survey.

"The Study Committee, headed by Dr. Benjamin Hoyer, Cincinnati, includes seven other pediatricians: Dr. John E. Brown, Jr., Columbus; Dr. I. R. Cohn, Toledo; Dr. J. Victor Greenebaum, Cincinnati; Dr. Robert B. Hauver, Cleveland; Dr. James G. Kramer, Akron; Dr. George C. Malley, Zanesville; and Dr. Wallace B. Taggart, Dayton.

"The purpose of this statement is to present an outline of the proposed reports of the Study Committee in accordance with plans developed by the Central Office of the American Academy of Pediatrics Study of Child Health Services.

"The material of these reports will fall into nine categories. They are: (1) Volume of Medical Care for Children; (2) Distribution of Physicians and Dentists; (3) Division of Care by Specialists and General Practitioners; (4) Make-up of Physicians' and Dentists' Practices; (5) Hospital Care for Infants and Newborn Children; (6) Special Hospital Care; (7) Outpatient Services; (8) Health Supervision for Children; (9) Community Health Services.

"It should be restated that in this study all information furnished by physicians and dentists is being treated as confidential. There will be no attempt to identify any individual or group. The aim is to form a picture of services available in the communities of the state rather than to examine the activities of any physician or dentist.

WHAT ARE THE ANSWERS?

"In the Ohio Study of Child Health Services we hope to get answers to a great many questions, some of which follow: What is the volume of medical care rendered to children? How does this amount vary with respect to the metropolitan character of the county? Are physicians and dentists available in all areas to care for children? Are there specialists as well as general practitioners? Who takes care of the children? What kind of training have the physicians and dentists had? What kind of practice do they carry on? What is the availability to general practitioners of hospitals admitting children? Where are the hospitals that take children? How many beds and hospitals are there? How far are these hospitals from where the children live? What are the hospitals like? What is the volume of care rendered to children in hospitals? Where are outpatient services available? Are there clinics for special services available? How much health supervision is given children? Who gives it? Where? Who gets it? For each community what services are available by official and voluntary agencies?

"In assembling and tabulating this data there will be no attempt to set standards of care. The material will be presented simply as facts and will be available to any and all who may wish to use the facts as a basis for planning medical care for children of the State. Following the factual reports the Study Committee or other Ohio members of the American Academy of Pediatrics may wish to undertake, independently or in cooperation with the Ohio State Medical Association, the Ohio State Dental Society, or the Ohio Department of Health, a program of recommendations for improving the medical care of children."

Rehabilitation of 1,025 Handicapped Completed by Ohio Bureau Last Year; Operation of Program Analyzed

FUNCTIONING under the State Department of Education and with the guidance of an advisory council and a medical professional advisory committee of 10, the Ohio Bureau of Vocational Rehabilitation during the year ending July 1, 1946, completed the rehabilitation of 1,025 vocationally handicapped persons.

Of $21,000 spent by the Bureau last year for medical and related services, $6,000 was paid out for diagnostic examinations, physical and psychiatric; $3,000 for surgery; and $12,000 for prosthetic devices, mainly artificial limbs. Hospitalization costs amounted to $2,000. A total of 205 persons received treatment by physicians at the expense of the Bureau.

The Bureau uses the Industrial Commission fee schedule as the basis for paying for medical treatment.

The history of the Bureau dates from 1921, soon after the passage of an act of the 66th Congress in June, 1920, which promoted vocational rehabilitation by reimbursing the states to the extent of 50 per cent of the cost of any state program.

LAW AMENDED IN 1943

Extensive changes in the national program were brought about however in the 78th Congress by the passage of Public Law 113, which was approved in June, 1943. This act amended the original law to make mandatory the preparation of a rehabilitation plan by each state.

The new law also raised the federal government's ante on matching to the extent of supplying 100 per cent of expenditures incurred in the administration of the state program; 100 per cent of the cost of rehabilitation services to war-disabled civilians, as well as the previous 50 per cent of the cost of rehabilitation services to other disabled individuals.

This act also extended the scope of services to include "any services necessary to render a disabled individual fit to engage in a remunerative occupation". This extended services to the mentally handicapped, and provided for surgical procedures to decrease physical handicaps or even remove or fully compensate for them. Previously physical restoration was limited to artificial appliances.

Ohio's plan, already in operation, was approved by the Federal Office of Vocational Rehabilitation, a part of the Federal Security Agency, in January, 1944.

ELIGIBILITY FOR REHABILITATION

According to the Ohio plan the eligibility of an individual for this service depends upon whether or not he is employable, that is, "that he is 16 years of age or older; that he can become physically competent to work; that he is mentally competent to manage his own affairs; that he does not require permanent custodial care; and that through rehabilitation training or other services, he may be presumed to be able to become substantially self-supporting in normal, sheltered, or home employment".

Generally, if four basic questions can be affirmatively answered, the individual is eligible for physical restoration:

"Is the condition static, i.e., relatively permanent, arrested, and relatively unprogressive?

"Will restorative measures remove or substantially reduce the handicap?

"After restoration procedures, will the client's employability be substantially increased?

"Is the client unable financially to provide these services?"

SERVICES OFFERED

Corrective services, including medical and psychiatric treatment, hospitalization, prosthetics, etc., are provided by the Bureau only when the client is deemed unable to pay the cost of the services. Diagnostic examinations for eligibility, counseling, and the actual training for an occupation are provided to the patient without cost.

The Bureau deals with innumerable types of handicaps in training, or re-training, individuals for an occupation which will fit their remaining capacities. Victims of industrial accidents; persons crippled by amputations, infantile paralysis, congenital malformations; tuberculosis and rheumatic fever sufferers; and individuals with speech defects and phychiatric disorders are frequently encountered.

A separate rehabilitation program of the Ohio Commission for the Blind handles those vocationally handicapped by loss of sight. Claude S. Perry, M.D., Columbus, is the consultant for this group.

NEEDS VARY

Needs of individuals vary with their handicap. One person may need vocational guidance and counsel, a complete training program under close supervision, and aid in obtaining employment; another may need only counsel and guidance; a third may need only an artificial appliance to enable him to return to employment; a fourth may need only assistance in securing employment for which he is already trained. In any event, rehabilitation is not considered complete until the person is satisfactorily employed.

PATIENTS MAY BE REFERRED

Physicians may refer patients desiring rehabilitation service to the Bureau by sending

them to any of the following offices of the Bureau: Akron, Room B-24, U. B. Bldg., 9 S. Main Street; Athens, Room 412, 8 N. Court Street; Canton, 804 Brant Bldg.; Cincinnati, Schmidt Bldg., 431 Main Street; Cleveland, 841 B. of L. E. Bldg.; Columbus, 83 S. High Street; Dayton, 143 S. Wilkinson Street; Toledo, 317 North Huron; and Youngstown, 318 Dollar Bank Bldg.

A medical form, R3, is supplied to the patient by the Bureau, and the Bureau pays a fee of $5 to the physician for conducting the examination and completing and returning the form.

ADVISORY COMMITTEE

Members of the State Professional Advisory Committee, as reorganized January 1, 1946, include: the chairman, E. Harlan Wilson, M.D., Columbus, orthopedics; Charles A. Doan, M.D., Columbus, internal medicine; Herbert D. Emswiler, M.D., Columbus, otolaryngology; Louis B. Blair, Columbus, hospital superintendent; Frederick M. Douglass, M.D., Toledo, general surgery; Milton Rosenbaum, M.D., Cincinnati, psychiatry; Herman J. Nimitz, M.D., Cincinnati, tuberculosis hospital superintendent; Albert D. Ruedemann, M.D., Cleveland, ophthalmology; Harold Feil, M.D., Cleveland, cardiology; and Walter J. Zeiter, M.D., Cleveland, physical medicine. Marlow B. Perrin, Columbus, is director of the Bureau.

COMING MEETINGS

Ohio State Medical Association, Cleveland, May 6-8, 1947.

American Medical Association, Atlantic City, June 9-13, 1947.

House of Delegates, American Medical Association, Semi-annual meeting, Chicago, Dec. 9-11.

Annual Conference of State Secretaries and Editors, Chicago, Dec. 7-8.

American Academy of Allergy, New York, Nov. 25-27.

American College of Physicians, Chicago, April 28-May 2, 1947.

American College of Surgeons, Cleveland, Dec. 16-20.

American Congress on Obstetrics and Gynecology, St. Louis, Sept. 8-12, 1947.

American Public Health Association, Cleveland, Nov. 12-14.

Annual Clinical Conference, Chicago Medical Society, Mar. 4-7, 1947.

National Society for the Prevention of Blindness, New York, Nov. 25-27.

National Congress on Rural Health, Chicago, Feb. 7-8, 1947.

National Conference on Medical Service, Chicago, Feb. 9, 1947.

National Congress on Medical Education, Chicago, Feb. 10-11, 1947.

Study Courses To Feature Program of Welfare Conference, Nov. 17-20

The Ohio Welfare Conference will hold its 56th annual meeting at the Deshler-Wallick Hotel, Columbus, November 17-20, with more than a score of leaders in private and public welfare and health work leading study course programs.

The study courses, 26 in number, are schedulued from 2 to 5 p. m. during the final three days of the meeting, with course leaders remaining the same throughout.

The opening general session is slated for 7:30 p. m. November 17, with Miss Bell Greve, director of the Cleveland Association for the Crippled and Disabled, and Mrs. Esther Sweeney, field representative of the American Social Hygiene Association, New York, on the speaking program.

State Welfare Director Frazier Reams will open the general session November 18 at 10:45 a. m. with the report on the activities of his department, and Arthur Glattke, superintendent of the Ohio Reformatory for Young Men, Mansfield, will discuss the problems of that institution.

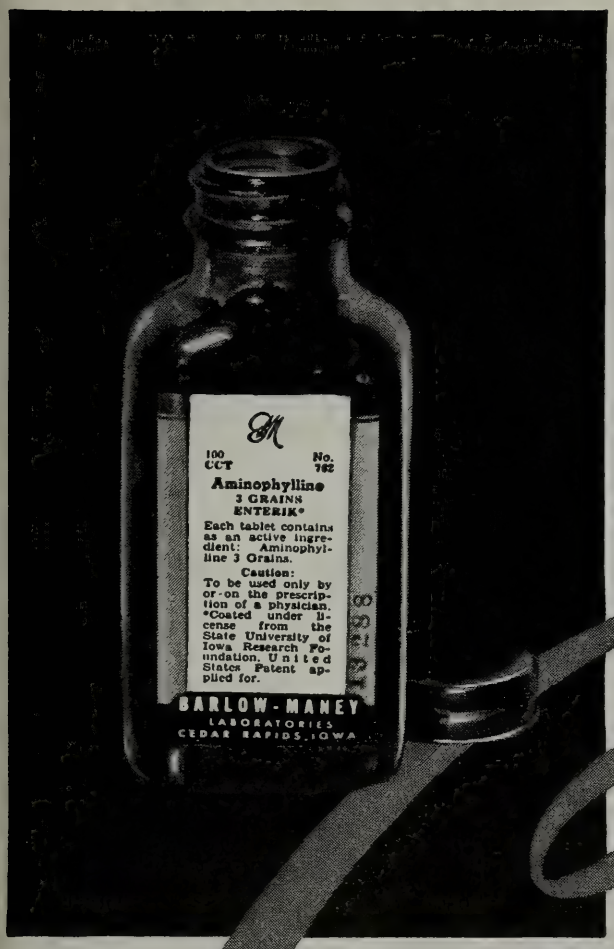
Grove Patterson, editor-in-chief of the Toledo Blade, will speak at 8 p. m. the same day.

The conference banquet will be held at 6:30 p. m. November 19. An address by Juvenile Judge Raymond P. Smith, president of the Conference will be heard at this time.

Leaders of the nine-hour study courses will include: George Lawton, Ph. D., consulting psychologist, Old Age Counseling Service, New York City, directing the course on "Services to the Aged"; Dr. Louis A. Schwartz, Detroit, "Psychiatric Approach to Family Problems"; Dr. Irene M. Josselyn, Chicago, "Emotional Development of the Individual".

Mrs. Mary S. Weaver, consultant on medical assistance, Bureau of Public Assistance, Social Security Administration, Washington, "Meeting Health Needs in Public Assistance"; A. David Bouterse, executive director, Ohio Welfare Council, "Public Welfare Organization and Administration".

Other study courses and their leaders will include: "Public Child Care, Goals and Opportunities", Miss Alice R. May, Children's Division, Michigan State Department of Public Welfare; "Foster Home and Child Placement", Miss Helen A. Wisgerhof, assistant professor in child welfare, School of Applied Social Science, Western Reserve University; "Finding and Developing Good Foster Homes", Mrs. Henrietta L. Gordon, information and publications secretary, Child Welfare League of America; "Principles and Methods in Adoptive Placements", Mrs. Cora M. F. Bish, case work supervisor, Toledo Child and Family Agency; "Case Work in Marital Counseling", Sidney J. Berkowitz, case work supervisor, Jewish Family Service Association of Cleveland; "Advanced Case Work Skills", Ralph Ormsby, executive secretary, Family Service Society of St. Louis, Mo.; "The Church and Social Work", Miss Virginia Blick, consultant to the Cincinnati Council of Churches; and "Mobilization of Welfare Resources in a Rural Community", Everett C. Shimp, associate professor of social administration, Ohio State University.



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In Memoriam

John Thomas Batte, M.D., Covington, Ky.; Medical College of Ohio, Cincinnati, 1906; aged 62; died Sept. 18; former member of the Ohio State Medical Association and the American Medical Association. Dr. Batte was formerly assistant superintendent at Longview State Hospital in Cincinnati, and during the recent war served as a member of the medical staff of the Wright manufacturing plant at Lockland. He is survived by his mother and two sisters.

Frank Riley Castleman, M.D., Columbus; Ohio State University College of Medicine, 1921; aged 69; died Oct. 9. Dr. Castleman was a veteran of 30 years' service in the Ohio State University department of physical education. An athlete in his own right, Dr. Castleman appeared in the Olympic games in 1906 and was captain of both baseball and track teams during his undergraduate career at Colgate. His widow and a brother survive.

William Albert Clark III, M.D., Springfield; Ohio State University College of Medicine, 1936; aged 37; died Sept. 25; member of the Ohio State Medical Association and the American Medical Association. Dr. Clark was former superintendent of the Clark County Sanatorium.

Michael J. Clouse, M.D., Somerset; Starling Medical College, Columbus, 1901; aged 75; died Oct. 1; member of the Ohio State Medical Association and the American Medical Association. Dr. Clouse was chairman of the legislative committee of the Perry County Medical Society in 1929. He had practiced medicine in Somerset for 45 years, and was at one time assistant chief of staff at St. Francis Hospital in Columbus. Dr. Clouse was active in civic affairs and was a member of the Catholic Church and the Catholic Order of Foresters. Surviving are his widow, a daughter, and one son, Dr. Michael Clouse, Jr., Somerset.

Linus Reed Cranmer, M.D., Steubenville; University of Michigan Medical School, Ann Arbor, 1915; aged 56; died Sept. 17; member of the Ohio State Medical Association; fellow of the American Medical Association and the American College of Surgeons. Dr. Cranmer had practiced medicine in Steubenville since 1917, where he was active in civic and social affairs of the community. He was a member of the Masonic and Elks lodges. Surviving are his widow, two daughters, a son, Dr. L. Reed Cranmer, Jr., U.S. Army Medical Corps, and a sister, Mrs. Carl Goehring, Steubenville.

Frank W. Daykin, M.D., Cleveland; Western Reserve University School of Medicine, 1879; aged 87; died Oct. 1. Said to be the oldest practicing physician in Cleveland, Dr. Daykin had maintained his office at the same location in that city for 67 years. He was a member of the executive board of the Pearl Street Savings & Trust Company and had been on the advisory committee of the old Union Trust Company. Surviving are his widow, a son, a brother, and a sister.

Welcome McClellan Elwell, M.D., Toledo; Starling Medical College, Columbus, 1890; aged 83; died Sept. 29. Dr. Elwell has practiced medicine in Toledo for 47 years. Surviving are his widow, a daughter, and two sisters.

John Conrad Kunz, M.D., Cincinnati; Cincinnati College of Medicine and Surgery, 1891; aged 81; died Sept. 18; member of the Ohio State Medical Association and the American Medical Association. Dr. Kunz practiced medicine in Cincinnati for 48 years prior to his retirement in 1940. He was a member of the Masonic Lodge and a trustee of the Methodist Church. A talented musician, he sang in Orpheus Club concerts for a number of years and was one of its pioneer members. His widow, a son, and two daughters survive.

Joseph V. Kofron, M.D., Cleveland; Western Reserve University School of Medicine, 1893; aged 77; died Sept. 26; former member of the Ohio State Medical Association and the American Medical Association. Dr. Kofron had practiced medicine in Cleveland for 52 years and was chief surgeon for the Corrigan-McKinney Steel Company for 15 years. He had been a member of the staff of St. Alexis Hospital since 1894. He had studied at the Universities of Vienna, Prague, and Berlin. Surviving are his widow and a daughter.

William Leonard, M.D., Fostoria; Western Reserve University School of Medicine, 1888, aged 84; died Sept. 23; former member of the Ohio State Medical Association and the American Medical Association. Dr. Leonard had practiced medicine in Fostoria for 58 years. He served as an officer in the U.S. Army Medical Corps in World War I, and was a member of the Masonic Lodge and First Presbyterian Church. His widow survives.

Joseph J. Manley, M.D., Cleveland; Humboldt Medical College, St. Louis, 1929; aged 46; died Sept. 15. Dr. Manley was a captain in the U.S. Army Medical Corps during World War II. He is survived by his widow, two brothers, and a sister.

Charles James Roach, M.D., Zanesville; Ohio State University College of Medicine, 1917; aged 57; died Sept. 21; member of the Ohio State



As Appetite Declines

WITH THE YEARS

The many somatic and emotional changes encountered in senescence are manifested in a variety of ways, especially by a decrease in appetite. Reduced energy expenditure, atrophic gastric changes, exaggerated food dislikes, and food intolerance all contribute, and not infrequently lead to a state of undernutrition. In older patients, this chain of events can easily produce excessive weakness and impaired stamina, adding to the burdens of senility. Ovaltine proves an excellent means of preventing these complications. Its wealth of essential nutrients, as indicated by the table of composition, aids in preventing malnutrition. Made with milk as directed, Ovaltine is a delicious food drink. Older patients enjoy it as a mealtime and between-meal beverage, and especially as a bedtime drink. Its low curd tension assures easy digestibility and rapid gastric emptying, hence appetite is not impaired.

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*Based on average reported values for milk.

Medical Association and the American Medical Association. Dr. Roach was president of the Muskingum County Academy of Medicine in 1938, and vice-president in 1933. He was chief of staff at Good Samaritan Hospital in Zanesville. For his service as a first lieutenant in the U.S. Army Medical Corps during World War I, he was decorated several times, and for his work as physician in several Zanesville war plants during World War II, he received a commendation from the President of the United States. He was a member of the Eagles Lodge and the Catholic Church. Surviving are his widow, a daughter, a brother, and a sister.

Jesse Burt Sampsell, M.D., Van Wert; Ohio Medical University, Columbus, 1903; aged 70; died Sept. 21; member of the Ohio State Medical Association and fellow of the American Medical Association. Dr. Sampsell was president of the Van Wert County Medical Society in 1929 and 1930, and delgate to the Ohio State Medical Association in 1928. He was an Army Medical Corps veteran of World War I and had served as Van Wert City Health Commissioner since 1943. He was active in hunting, golfing, and fishing; and a member of the Knights of Pythias Lodge and the First Presbyterian Church.

John DeForest Smith, M.D., Dayton; Eclectic Medical College, Cincinnati, 1898; aged 75; died Sept. 22; former member of the Ohio State Medical Association and the American Medical Association. Dr. Smith was a physician for 48 years, and practiced for 41 years in Dayton. He had retired prior to World War II, but returned to practice because of the shortage of medical help in the community. Interested in flower growing, Dr. Smith was a member of the Montgomery County Horticultural Society. He was a member of the Masonic Lodge and the Baptist Church. Surviving are a daughter, a brother, and a sister.

James Oscar Starr, M.D., Greenville; Starling Medical College, Columbus, 1901; aged 77; died Sept. 17; former member of the Ohio State Medical Association and the American Medical Association. Dr. Starr was vice-president of the Darke County Medical Society in 1933, and secretary in 1924 and 1925. He retired from active practice in 1939. He was a member of the Masonic Lodge. Surviving are his widow, a son, a daughter, and a brother.

George Bernard Topmoeller, M.D., Cincinnati; University of Cincinnati College of Medicine, 1910; aged 59; died Oct. 3; member of the Ohio State Medical Association and the American Medical Association; fellow of the American College of Physicians and diplomate of the American Board of Internal Medicine. Dr. Topmoeller was secretary of the Academy of Medicine of Cincinnati in 1933. He had practiced medicine in Cincinnati for 36 years and was chief of the medical staffs of St. Mary's and Good Samaritan Hospitals. While attending Xavier University he was a member of the football team, and later became active in the alumni affairs of that institution. Surviving are his widow, two daughters, and three brothers, including Dr. William Topmoeller of Cincinnati.

Georgette S. Williams, M.D., Hamilton; Cincinnati College of Medicine and Surgery, 1900; aged 84; died Oct 1; former member of the Ohio State Medical Association and the American Medical Association. Dr. Williams practiced medicine in Hamilton from 1900 until her retirement in 1937. She is survived by a son, Dr. Charles A. Williams, Marietta.

Three Recent Staff Appointments Announced by A.M.A.

The American Medical Association has announced the appointment of Frank G. Dickinson, Ph.D., associate professor of economics, University of Illinois, as economist for the Bureau of Medical Economic Research.

A widely known insurance consultant, Dr. Dickinson will take a year's leave of absence from the university, where he has been in the economics department since 1921.

Howard Brower, recently discharged from military service, has joined the staff of the Council on Medical Service, where he will assist in the division of prepayment medical care plans. He has served six years with the insurance department of the State of Michigan and with private insurance companies.

Also new to the staff of the Council on Medical Service is L. S. Kleinschmidt, who will assist with the rural aspects of prepaid medical care programs. He has had 32 years' experience in developing organizations to meet rural problems.

Medical Education and Licensure Meeting Feb. 10-11, 1947

The 43rd annual session on medical education and licensure and related topics will be held at the Palmer House, Chicago, February 10 and 11, 1947, under the auspices of the A.M.A. Council on Medical Education and Hospitals and the Federation of State Medical Boards.

Some of the problems to be considered include, the overcrowding of undergraduate universities and colleges, the reconversion of the medical school programs to peacetime operation, the unprecedented demand for residency training, and the affiliation of medical schools with veterans' hospitals.

Special meetings to be held concurrently will include the Executive Council of the Association of American Medical Colleges, the Advisory Board for Medical Specialties, and the National Board of Medical Examiners.

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Laryngoscope 1935, XLV, No. 2, 149-154

TO THE DOCTOR WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

Value and Use of Vital Statistics in Public Health Administration

MEN more versed and experienced than I would find the task of elucidating the implication of statistical data in medicine and public health, a real challenge. The most that can be accomplished at this time is to portray a few selected implications based on my own limited experience.

At the risk of being redundant, the preamble should include:

1. That vital statistics have relative importance to professional statisticians, to health officers, to specialists in the over-all field of public health, also to the average lay person. All, however, are affected by its manipulation and, therefore, must be concerned with the processes involved.

2. Complete uniformity in the handling or the use of vital statistics is not yet a reality and probably never should be, due to the existence of different levels of health administration. A variation of services are performed or required which are dependent upon both the area served and the make-up of the population. The application of well defined methods to vital statistics, however, is a dire necessity.

3. The value of statistics and the degree of proper usage in a health department is dependent on adequate budgets and the employment of adequately trained personnel.

THE "CENTRAL NERVOUS SYSTEM"

These generally understood preliminary remarks emphasize necessary limitations in the handling of vital statistics. On the other hand, it can be stated that the distribution of public health services, their coordination or their administration can be compared with a business venture. Health services are provided by bureaus and divisions, each of which must carry on its work with definite objectives. The health officers also must bear in mind budgets, employment of personnel, production, advertising, and selling a service.

Statistics are considered to be the backbone of a larger business organization and, as such, serve as a central nervous system which permeates and affects the most remote part of the business anatomy. Whether we wish to concede that point or not, health departments are business organizations.

COMPLETE RECORDING ESSENTIAL

The concept of complete recording of vital facts or its registration is not purely academic, but, on the contrary, it is practical and a common necessity.

Editor's Note:

The accompanying article is an abstract of an address delivered at the Twenty-Seventh Annual Conference of Health Commissioners of Ohio with the Ohio Department of Health in Columbus, September 5 and 6, by A. J. Borowski, D.P.H., registrar and superintendent of the Bureau of Vital Statistics, Toledo Board of Health.

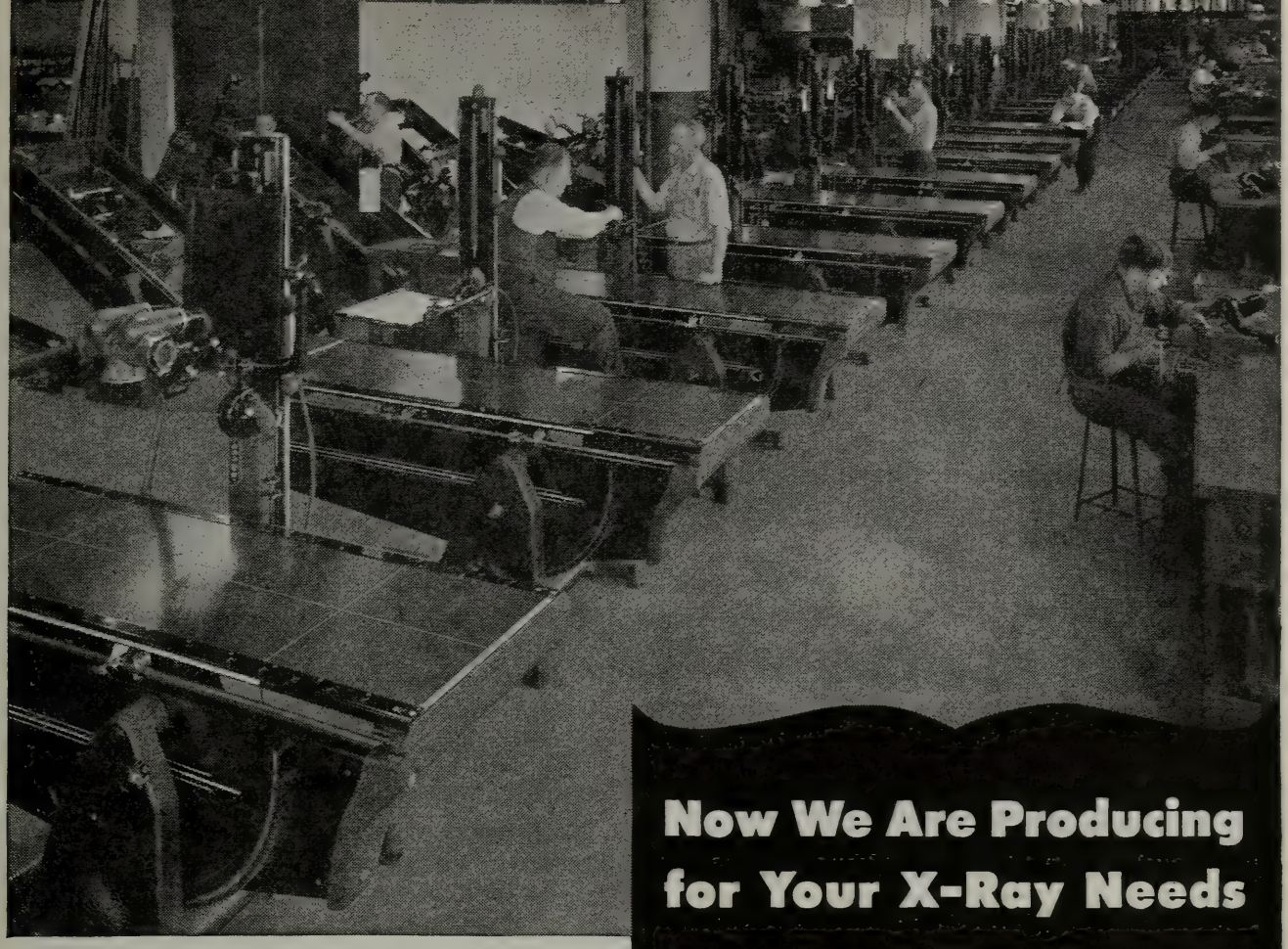
It emphasizes not only the value of vital statistics and the importance of maintenance of accurate, complete records but also the vital role which the physician plays in the collection and analysis of such data.

It is the hope of The Journal that each physician will read every line of Mr. Borowski's excellent presentation and then pledge himself to give his local registrar complete cooperation and assistance.

One and one-half per cent of our population die each year. As a result of each death, there are problems of inheritance or property and insurance settlements. There are legal requirements for determining date of birth, age, family relationship, and a true cause of death. Some of these factors are personal matters; others of public interest. Thus, complete and correct registration is paramount.

Approximately twice as many are born as die in any given period. Will this ratio continue? A ratio which is necessary for an ever-growing and productive population is a question which will take on added impetus in the next few years. As in the case of death certificates, a birth certificate is not simply an inanimate object, a piece of paper filed away in the archives of some state health department building. A birth certificate in reality is a vital document, an identification tag, almost continuously required as proof of right to be a citizen, to vote, to learn, to marry, to partake for that matter in any significant engagement in life.

Our objective as public health experts is to so conduct our professional organization, not only to see the life span constantly increased, but to assure everyone of our charges a safe and healthy environment in which to grow and live; furthermore, that each person will remain independent and productive to the very end of his earthly existence. This is no small assign-



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ment nor can it be accomplished without good bookkeeping of records or research.

FAILURES AND WEAKNESSES

Too frequently, there is failure through carelessness to adequately complete or file a record. Such a fault is very likely due to lack of appreciation or cognizance of the importance of vital records. Two extremes are possible in record keeping and do exist. Either there are no records at all or too many for efficient use.

Likewise, obtaining answers to questions for the purpose of creating an impression or for the sake of red tape, could be exemplified at length. This is a real pitfall in the development of appreciation for vital statistics.

On the other hand, failure to comply in answering carefully selected and important queries on vital records for one reason or another is a serious detriment and results only in a misguided effort.

VARIOUS GROUPS CONCERNED

It behooves each public health administrator to emphasize repeatedly the importance of accurate and complete record keeping to all members of his community, but to the following in particular:

1. **The parents, the attending physician at birth, and the hospital authorities** who have individually or collectively the responsibility for registering the newborn. This is a serious assignment, a moral as well as a legal obligation.

2. **The medical profession** which cherishes the responsibility of attending the sick, putting forth great amount of energy to cure and to stem the tide of spreading communicable destruction of human life, must be convinced of the value of morbidity reporting. The practicing physicians actually are obligated to send warning signals and to report all communicable diseases to the health officer who serves as a controlling factor or watch tower for his community.

3. **The medical examiner or coroner** who serves as a liaison officer between the legal and medical professions is another vital cog in the wheel of vital statistics. Complete and efficient exchange of vital information is highly important with respect to accidents, homicides, and suicides. The accident prevention program has much significance in public health administration, but can be stressed only by a review and careful analyses of death certificates, processed through the office of the coroner. The coroner's relationship should be as intimate with officials of the health department as it is with the legal department.

RESPONSIBILITY OF PHYSICIAN

4. **The physician,** last in attendance during a course of illness which terminates in death, must be impressed with having a definite obligation to fulfill to the family of the patient and, by law, to the city and state governments, which allow him the privilege of medical practice. The physician in this case must sign and submit a death certificate to the funeral director, prepared carefully and completely, without delay and without reluctance.

Some physicians labor under the illusion that a health officer is imposing or is meticulously meticulous when existing regulations make it mandatory to subsequently inquire about missing information or when causes of death are ambiguously stated and need clarification.

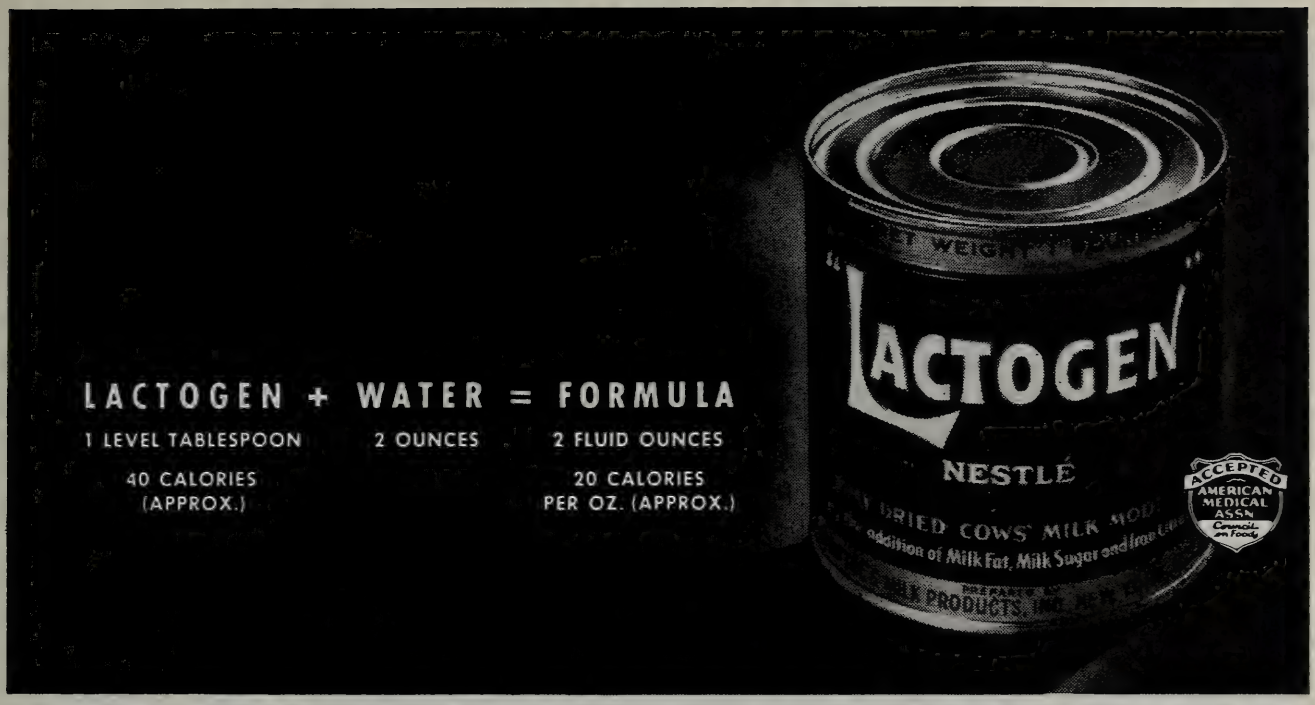
Numerically, the physicians who display animosity toward the execution of certificates of death, are not great; nevertheless, occurrences are too frequent for comfort. That there exist difficulties at times for the doctor and others concerned with death registration can be taken for granted. The plea must be, however, for voluntary and willing cooperation on the part of the medical society in order to achieve the optimum of accuracy according to the rules.

It has been observed that approximately 75 per cent of all death certificates have listed more than one cause of death. Therefore, to choose the underlying cause of death by anyone other than the attending physician is no simple task. Yet, four out of five death certificates listing contributory causes are submitted to health departments without indication of a principal choice on the part of the attending physician. To complicate matters further, 50 per cent of choices made by the physician are in disagreement with the International Statistical Rule. Also, too many of the coroner's cases receive a verdict of valvular heart disease.

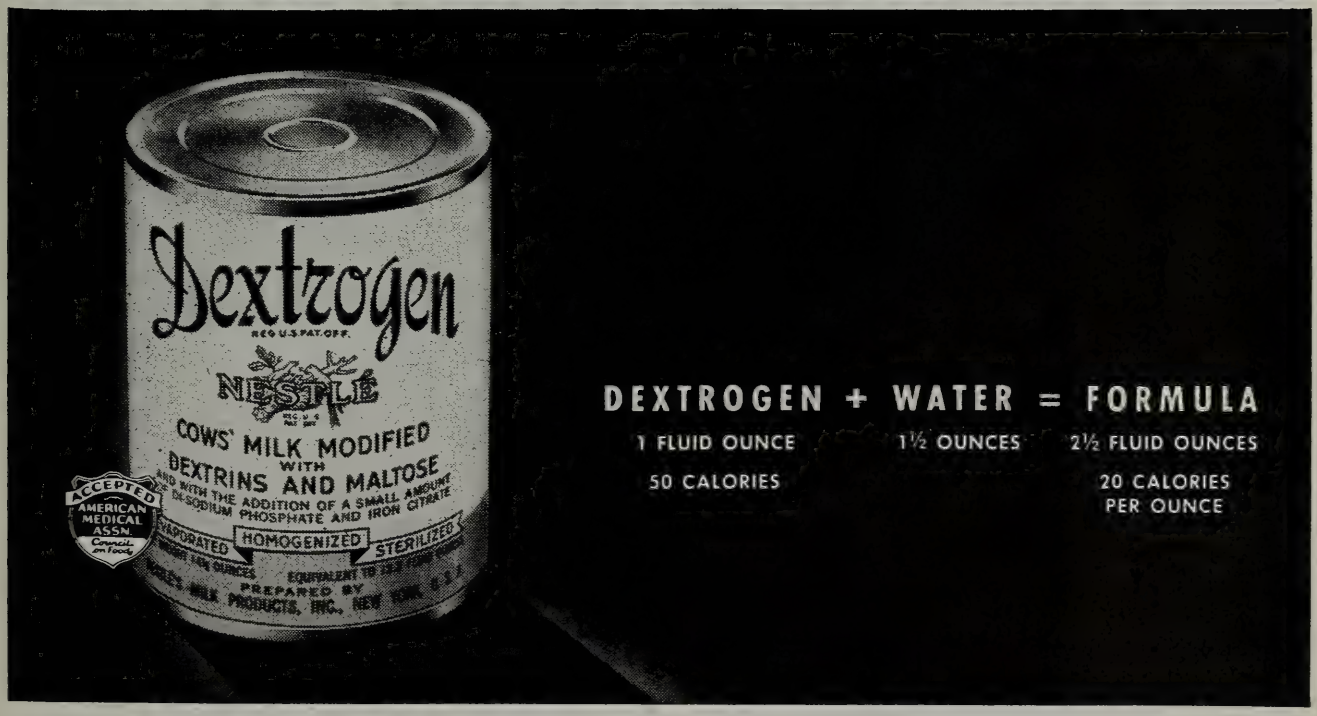
Added to this dilemma, still another instance of a contributory error to accurate vital statistics is the result of pressure placed on attending physicians by families at times, but more frequently by representatives of insurance companies, to complete a diagnosis on the cause of death post-haste.

In a sudden death of early infancy, for example, diagnosis of the actual cause of death is difficult. It might be difficult even with an autopsy, but the pressure is there for the doctor to sign a death certificate with all speed in order to settle a financial claim. It would not appear proper to state the cause of death as "undetermined" in the eyes of the average physician; therefore, a choice, such as "gastro-enteritis" appears sedate enough and is so stipulated on the certificate of death.

Suffice it to say that our concern must be with the achievement of maximum accuracy in line with the rules of the game. That concern



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is fundamental if vital statistics which we use, are to be significant and comparable.

FUNERAL DIRECTOR'S ROLE

6. **The funeral directors** also must have their attention called to the responsibility of completing the personal history on each decedent, and to work closely with the registrar of their district. Their service, which is sold to the family, includes the proper execution of a very important legal and vital document. The death certificate must bear his own hand-written signature, that of the physician, that of the informant, and the registrar's. To obtain this end, the funeral director must have patience and tact, and he needs the cooperation of both the physician and the registrar. The responsibility of obtaining a completed death certificate does not terminate his legal obligation since a burial permit also must be procured from the registrar before interment is permitted by law. This last statement leads us to the next group.

7. **The cemetery sextons** have the responsibility of making the last official entry on the bookkeeping ledger of human life. Again, by law, the sextons can not perform this act without possession of a burial permit. Unless their attention is called to this fact from time to time, human consideration for the difficulties encountered or as related to them, by the funeral director, may serve as a justifiable reason to overlook the law. Consequently, the funeral director might then overlook the necessity of registering the death certificate with the health department.

8. **The staff members of the health department** must be reminded that neither their assignments nor their accomplishments can be retained in the mind indefinitely. They must be recorded. Complete and daily record keeping is a must, because either illness or a decision to sever association with the department would result in a complete gap of orderly public health service.

GOOD RULE OF THUMB

Incidentally, a good rule of thumb to bear in mind when field records are made is that of the Five W's. **WHO** was seen? **WHY** was the inspection or interview made? **WHEN** was it made? **WHERE** did it take place? **WHAT** was accomplished?

If the statements in the discussion thus far can be accepted as sound, recognizing at the same time the many complexities of the human race and their involvement in the administration of public health, grave consideration must be given to adequate record keeping and to the task of making statistical evaluations on progress or lack of progress made in each of our communities.

The general impression today, contrary to that of several years ago, is that the subject can not be dismissed as incidental to intelligent planning and to the furnishing of adequate public health service. The necessity of informing the public on health matters and the public's acceptance of the health department products make it doubly important to have complete reports on the accomplishments of health department aims supported by facts.

VALUE OF VITAL STATISTICS

The value of vital statistics is for all intents and purposes synonymous with its use. There is a positive correlation between the use and value of vital statistics. In order to enlarge upon the subject, the most readily recognized values appear to be:

a. Doing away with a hit and miss emphasis on needed public services.

b. Providing supporting evidence for minimizing certain programs and placing emphasis on others.

c. Enables investigation to be made of demographic and public health data; also, it makes for the discovery of limitations or effectiveness of the health department functions.

d. Statistical work will serve as a base for planning and logical organization.

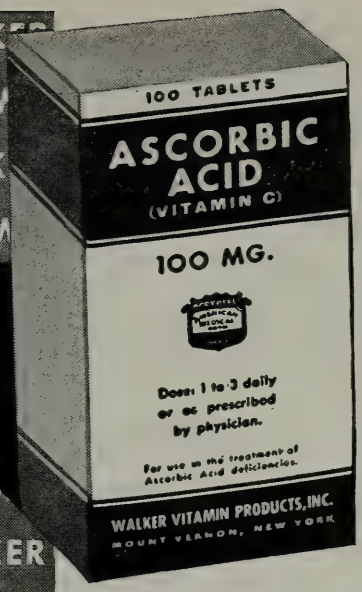
e. The reading public is very much interested in health conditions. Thus, health statistics can be employed as a nucleus for many of the releases to the press or as a decoy for placing emphasis on such programs as vaccinations or immunizations.

f. The launching of new programs will be more successful when supported with vital statistics data.

g. The public health nurse needs to know the infants who are the first born in a family, those who are under-weight, and those with congenital malformation, all of which can be obtained in an orderly fashion from a birth certificate. This is a definite requirement if the infant hygiene program is to be sound and complete.

h. In a maternal hygiene program among other necessary recorded information, a death certificate of a mother along with the birth, stillbirth, or death certificate of the child, prepares the nurse for more intelligent action.

i. Knowledge of the percentage of colored, the age distribution of the population served, the segregation of data dealing with nonresidents, an account of incidence of communicability by small segments of the entire area served, and, finally, comparability of statistics for areas similar in size, are of extreme value to the health officer and



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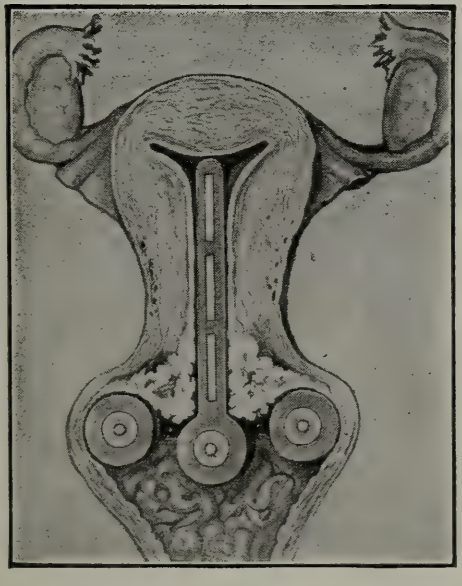
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SUMMARY AND CONCLUSIONS

To recapitulate:

1. Every business organization periodically has an accounting of funds and of accomplishments, and though in public health departments, the subject of profits and loss plays a non-important role, nevertheless, this is not sufficient justification for neglecting to keep good records and to forego statistical evaluations. Neglect in this instance handicaps the health officer not only in the management of his department but leaves him helpless before his board when a necessary increased budget is contemplated. A simple observation of the statistical treatment applied to vital records in insurance companies, as compared with health departments, will emphasize the point being made.

2. In establishing records or evaluation systems, frequently too little thought is given to the subject in relation to its need, its everyday value, or its usability.

3. To a large majority of public health workers, record keeping is a tedious chore, but these workers are not called upon as are health officers to explain existing facts which must be based on well defined accumulative records.

4. Vital bookkeeping can be put to use in many ways, pointing out weaknesses of function in bureaus. The value which will accrue, however, will be dependent on the extent of its use and on the time and attention devoted to the subject.

5. Finally, without the use of proper vital statistics records, full realization of a public health program is extremely difficult, if not next to impossible. With the advancement of public health techniques and with greater emphasis being placed on personal rather than environmental hygiene, health education and information now remains the chief tool for the complete realization of our objective. This implement can not be used adequately without record keeping or statistical involvement.

The use and value of vital statistics in public health administration is necessary and highly significant. It can not be referred to as incidental to other public health specialties. The science of vital statistics has been slow in development, it is true. Each succeeding year, however, is witness to its added influence on medicine and on public health.

The Third American Congress on Obstetrics and Gynecology will be held September 8-12, 1947, in the Municipal Auditorium in St. Louis. Dr. Fred L. Adair, Chicago, is general chairman. Previous congresses were held in 1939 and 1942.

Do You Know - - -

The Hoover Pavilion of Cleveland City Hospital has been scheduled to open as a state-operated mental receiving hospital, following settlement of litigation which challenged the city's right to transfer the building to the State of Ohio. A sum of $726,000, appropriated by the Ohio General Assembly, will be used to make improvements in the unit, which will provide outpatient service for mental patients.

* * *

Reports from Washington indicate that the total cases of infantile paralysis in the U. S. this year may reach between 23,000 and 24,000 cases. The total of 19,029 for 1944 has already been exceeded, placing 1946 as the second worst year to 1916, when the total was 27,363. Although the number of cases is now decreasing, the decrease is not as rapid as usual, according to the report.

* * *

The American Legion and its auxiliary, through the American Heart Association, has awarded two fellowships to veteran doctors for the study of rheumatic heart diseases. The awards have been made to the New York University College of Medicine and the House of the Good Samaritan in Boston, Mass.

* * *

The Annual Clinical Conference of the Chicago Medical Society will be held March 4, 5, 6, and 7, 1947, at the Palmer House, Chicago. The Society advises conferees to make their hotel reservations early.

* * *

State Health Director Roger E. Heering has issued a request that only husbands, and perhaps parents, visit maternity patients in Ohio hospitals. He explained that large numbers of visitors are causing undue exposure of patients in crowded wards and diverting nurses from vital duties in order to "police visitors".

* * *

"The History of Medicine in Art", an exhibition of prints collected by Clements C. Fry, M.D., Yale University, is being shown at the Cleveland Health Museum until November 15.

* * *

A million dollar expansion program which will more than double the floor space devoted to pharmaceutical research and production has been inaugurated by the Pitman-Moore Company Division of Allied Laboratories, Inc., Indianapolis.

* * *

Dr. Robert H. Bishop, director of University Hospitals, Cleveland, was inducted as president of the American College of Hospital Administrators at the 12th annual meeting of that group in Philadelphia.

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ACTIVITIES OF COUNTY SOCIETIES

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

BUTLER

Dr. Elmer P. R. Maurer, Cincinnati, spoke on "Chest Surgery", at the September 26 meeting of the Butler County Medical Society, held at Hamilton Club in Hamilton.

At the October 30 meeting, held at the Colony Restaurant, Middletown, Dr. Robert A. Lyon, assistant professor of pediatrics, University of Cincinnati College of Medicine, presented a paper on rheumatic fever.—Bulletin.

CLINTON

Dr. J. H. Frame, Wilmington, spoke on "Clinical Allergy", at the October 1 meeting of the Clinton County Medical Society, at Wilmington.—R. W. DeCrow, M.D., secy.

HAMILTON

Dr. Elliott P. Joslin, clinical professor of medicine, emeritus, Harvard Medical School, discussed "The Ambulatory Diabetic and the Family Doctor", before the Academy of Medicine of Cincinnati, meeting at the College of Medicine Auditorium, Cincinnati, October 15. The author of a textbook on diabetes now in its eighth revision, Dr. Joslin is the medical director of the George F. Baker Clinic at New England Deaconess Hospital, and consulting physician to the Boston City Hospital.—Bulletin.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

MONTGOMERY

"Thiouracil in the Management of Goiter", was the subject of a paper presented by Dr. Robert C. Austin, Dayton, before the October 4 meeting of the Montgomery County Medical Society, held in the auditorium of the Fidelity Building in Dayton.—N. E. Leyda, M.D., president.

Dr. George A. Woodhouse, Pleasant Hill, a delegate to the American Medical Association, addressed the general practice section of the Montgomery County Society September 25 at the Fidelity Building in Dayton. His subject was "The Practitioner of Today—Tomorrow". He also discussed the 1946 meeting of the American Medical Association in San Francisco and the question of a general practitioners' board.—News Clipping.

Third District

(COUNCILOR: J. CRAIG BOWMAN, M.D., UPPER SANDUSKY)

LOGAN

A lecture on the treatment of diabetes was presented by Dr. O. P. Allen, Akron, before the monthly dinner meeting of the Logan County



Medical Society, held October 4 at the Hotel Logan, Bellefontaine.—News Clipping.

Fourth District

(COUNCILOR: A. A. BRINDLEY, M.D., TOLEDO)

LUCAS

At the general meeting of the Academy of Medicine of Toledo and Lucas County October 4, at the Toledo State Hospital, Dr. Max T. Schnitker, Toledo, presented a paper on "Pre-Frontal Lobotomy". Dr. J. E. Duty, superintendent, reported on the activities of the hospital, and Dr. N. F. Hamilton presented a demonstration on Narcosynthesis.

Oct. 11—Section of Pathology, Experimental Medicine, and Bacteriology, Academy Building, "Hypersplenism—Its Pathology and Clinical Manifestations", Dr. Emmerich von Haam, professor of pathology, Ohio State University College of Medicine.

Oct. 18—Medical Section, Academy Building, "Disturbances of Speech as Related to Medicine", Herbert C. Weller, Sc.D., Toledo.

Oct. 25—Surgical Section, Academy Building, Lecture by Dr. A. A. Marchetti, assistant professor in obstetrics and gynecology, Cornell Medical Center, New York City.—Bulletin.

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

ASHTABULA

The Ashtabula County Medical Society met October 8, at the Hotel Cleveland, Conneaut. Dr. Raymond J. Rickloff, Erie, Pa., presented a paper on "Common Skin Disorders and Recent Trends in Syphilology".—News Clipping.

CUYAHOGA

Oct. 2—Pediatric Section, City Hospital, "Empyema in Prematures—Two Recoveries Under Penicillin", Dr. Margaret Dowell; "Myopia Suggesting Brain Tumor", Dr. F. F. Silver; "Pulmonary Infiltration Suggesting Tuberculosis", Dr. W. H. Gronemeyer.

Poliomyelitis: "Eighth Nerve and Eye Signs",

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Oct. 4—Clinical and Pathological Section, St. Vincent Charity Hospital, "Associated Sub-deltoid Bursitis, Coronary Thrombosis and Gout", Dr. J. P. Anderson; "Lupus Erythematosus Disseminatus", Drs. C. S. Stone and G. A. De Oreo; "Traumatic Rupture of the Small Intestine", Dr. W. H. Odell; "Anatomical Principles Underlying Radical Mastectomy", Dr. J. E. Hallisy; "Carcinoma of the Trachea", Drs. C. W. Engler and J. Robert Andrews; "Improvements in Excretory Urography", Dr. H. R. Trattner.

Oct. 9—Internal Medicine Section, Herrick Room, Medical Library, "Anti-coagulant Therapy", Dr. John W. Martin, Jr.

Oct. 11—Combined Meeting, Experimental Medicine Section and Cleveland Section of the Society of Experimental Biology and Medicine, Institute of Pathology Amphitheater. "The Effects of the Atomic Bomb in Hiroshima", Dr. Hymer L. Friedell; "The Study of Glycogen Metabolism with Carbon Isotopes", Harland G. Wood, Ph.D., Victor Lorber, M.D., Ph.D., Nathan Lifson, M.D., Ph.D., and Warwick Sakami, Ph.D.; "The Use of Radioactive Isotopes for Thyrotrophic and Growth Hormone Assays", Albert M. Potts, Ph.D., Betty L. Rubin, M.S., and Ralph I. Dorfman, Ph.D.; "The Use of Radioactive Sodium for Adrenal Cortical Hormore Studies", Mary Feil, M.S., Dr. Dorfman, and Dr. Potts.

Oct. 16—Obstetrical and Gynecological Section, Herrick Room, "Emotional Problems in Gynecological Practice", Dr. Edward O. Harper; "Emotional Problems in Obstetrical Practice", Dr. Douglas D. Bond.—Bulletin.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M.D., AKRON)

MAHONING

Dr. Richard H. Freyberg, associate professor of clinical medicine, Cornell University, New York City, spoke on "Practical Problems in Diagnosis and Management of Common Forms of Arthritis", before the October 15 meeting of the Mahoning County Medical Society, held at the Youngstown Club.

At the November 19 meeting, also at the Youngstown Club, the society will hear Dr. Robert S. Palmer, associate physician and chief of hypertension clinic, Massachusetts General Hospital, discuss "The Syndrome of Cerebral Circulatory Insufficiency in Arterial Hypertension with Particular Reference to Malignant Hypertension".—Bulletin.



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PORTAGE

Dr. Walter Pritchard, associate professor of medicine at Western Reserve University, presented a paper on "Blood Coagulation Factors and their Practical Applications", before the October 3 meeting of the Portage County Medical Society, held at Robinson Memorial Hospital, Ravenna.—E. J. Widdecombe, M.D., secy.

SUMMIT

"Problems in the Diagnosis of Coronary Disease", was the subject discussed by Dr. Harold Feil, associate clinical professor of medicine, Western Reserve University, at the October 1 meeting of the Summit County Medical Society, held at the Nurses' Home, City Hospital.

TRUMBULL

At its September 19 meeting the Trumbull County Medical Society heard Dr. C. J. De Lor, Columbus, talk on gallbladder and liver diseases. On October 17, Dr. William Andre Nosik, Cleveland Clinic, discussed, "Common Neurological Disorders in Everyday Life". Both meetings were held at the Warner Hotel in Warren.—E. G. Caskey, M.D., secy.

Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

BELMONT

Members of the Belmont County Medical Society met September 12 at the Bellaire City Hospital. Dr. W. Miles Garrison, medical director of the Belmont Sanatorium presented an X-ray reading demonstration. Following the program the members were dinner guests of the hospital. —News Clipping.

TUSCARAWAS

Dr. Robert M. Zollinger, professor of clinical surgery at the Ohio State University College of Medicine addressed a joint meeting of the Coshocton and Tuscarawas County Medical Societies, October 9 at the High School Building in Newcomerstown. He spoke on "The Management of Acute Cholecystitis".

Eighth District

(COUNCILOR: ARTHUR J. TRONSTEIN, M.D., NEWARK)

FAIRFIELD

The Fairfield County Medical Society will hear an address on the subject, "When is Surgery Indicated for Gastric or Duodenal Ulcer?" by Dr. Robert M. Zollinger, professor of clinical medicine, Ohio State University College of Medicine, at the December 10 meeting of the society at the Lancaster Hotel, Lancaster. The meeting will begin at 11:30 a. m.

Dr. Arthur J. Tronstein, Eighth District Councilor, Newark, addressed the October 8 meeting of the society on the subject "Facing the Prob-

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lems of the Medical Profession". The meeting was held in Lancaster.

MUSKINGUM

Dr. Alexander T. Bunts, associate neuro surgeon at the Cleveland Clinic, spoke on "Sciatic Pain Due to Protruded Inter-Vertebral Discs", before the Muskingum County Academy of Medicine, October 2, at the University Club, Zanesville.—Beatrice T. Hagen, M.D., secy.

Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORTSMOUTH)

SCIOTO

The Ohio State Medical Association's plan for home-town treatment of veterans with service-connected disabilities was discussed by Dr. M. J. Werner, chief medical officer of the Cincinnati regional office of the Veterans Administration before the October 14 meeting of the Hempstead Academy of Medicine in Portsmouth.—News Clipping.

Tenth District

(COUNCILOR: H. M. CLODFELTER, M.D., COLUMBUS)

FRANKLIN

Dr. Jerry C. Price, of the Neurological Institute, Columbia University, New York City, and consultant for the project on epilepsy in Ohio, spoke on the care of the epileptic person before the October 21 meeting of the Columbus Academy of Medicine held at the Art Gallery in Columbus.—Bulletin.

ROSS

Dr. Mary Louise Scholl, Children's Hospital, Columbus, was the speaker at the dinner meeting of the Ross County Academy of Medicine, held at the Lynne House, Chillicothe, October 10. Her subject was "The Rh Factor".

Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

LORAIN

The regular monthly meeting of the Lorain County Medical Society was held October 8 at Castle-on-the-Lake, Lorain. Dr. W. J. Engel, department of urology, Cleveland Clinic, spoke on "The Present Status of Hormone Therapy in Urology".—L. H. Trufant, M.D., secy.

Academy of Allergy Invites Physicians

The American Academy of Allergy will hold its annual convention at Hotel Pennsylvania, New York City, November 25-27. All physicians interested in allergic problems are invited to attend the sessions as guests of the Academy without payment of registration fee. Advance copies of the program may be obtained by writing to the chairman on arrangements, Dr. Horace S. Baldwin, 136 East 64th Street, New York City.

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WOMAN'S AUXILIARY NEWS

By MRS. FRED W. BROSIUS, MIDDLETOWN
Chairman, Publicity Committee

ANNUAL CONFERENCE AND BOARD MEETING

The second annual conference for county presidents and presidents-elect of the Woman's Auxiliary to the Ohio State Medical Association was held Wednesday, September 18, at the Deshler-Wallick Hotel, Columbus.

Presidents attending were: Mrs. David Heusinkveld, Hamilton County; Mrs. Donald M. Traul, Summit; Mrs. C. W. Smith, Marion; Mrs. M. A. Mulvania, Allen; Mrs. G. M. Mills, Ashtabula; Mrs. D. D. Bibler, Crawford; Mrs. C. J. Holley, Belmont; Mrs. P. D. Hisrich, Tuscarawas; Mrs. J. A. Toland, Guernsey; Mrs. Earl Baxter, Franklin; Mrs. J. F. Lee, Knox; and Mrs. Harold Crumley, Ross County.

Presidents-elect were: Mrs. Robert Lemmon, Summit County; Mrs. Charles Griebling, Crawford; Mrs. Robert Curl, Lucas; Mrs. R. M. Swan, Guernsey; Mrs. Donald J. Alspaugh, Franklin; Mrs. Charles Tramont, Knox; and Mrs. R. A. Campbell, Richland County.

Mrs. Paul A. Davis, Akron, president of the Auxiliary, called the meeting to order at 9:30 a.m., September 18. Roll call of conference members and minutes of the last meeting by the sec-

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retary, Mrs. E. B. Gillette, Toledo, were followed by the treasurer's report by Mrs. Dean Nesbit, Youngstown. Reports given by the county presidents were instructive and inspirational. The county auxiliaries are to be congratulated upon the progress made in their varied activities.

Luncheon was an enjoyable affair and concluded by an excellent talk given by Dr. H. M. Clodfelter, Columbus, a member of the Auxiliary Advisory Council.

Following luncheon the business session was resumed and reports were given by the following district directors and state committee chairmen: Mrs. E. P. Trittschuh, Lewisburg; Mrs. J. R. Tillotson, Lima; Mrs. Rolin Kuebbler, Toledo; Mrs. A. M. Mills, Ashtabula; Mrs. J. W. Calhoon, Uhrichsville; Mrs. T. R. Mattocks, Marietta; Mrs. George W. Cooperrider, Columbus; Mrs. C. H. Bell, Mansfield.

Chairmen of standing committees: Mrs. Roswell S. Fidler, Columbus, finance; Mrs. B. C. Diefenbach, Martins Ferry, Hygeia; Mrs. David Beers, Warren, program; Mrs. C. F. Wharton, Akron, legislation; Mrs. D. M. Keating, Cleveland, public relations; Mrs. J. L. Stevens, Mansfield, historical; Mrs. Harold K. Mouser, Marion, organization; and Mrs. Fred Brosius, Middletown, publicity.

Chairmen of special committees: Nurses' Scholarship Loan Fund reported by Mrs. Ralph W. Hoffman, Columbus, and emblem by Mrs. John A. Riebel, Columbus.

A special dinner party at the Maramor Restaurant was a fitting conclusion to the program.

The Executive Board convened at 8 a.m. September 19, with a breakfast at the Deshler-Wallick Hotel. Charles S. Nelson, executive secretary to the Ohio State Medical Association, was the guest speaker.

At 9:30 a.m. Mrs. Davis called the meeting to order and brief reports were heard from the district directors and chairmen of standing and special committees:

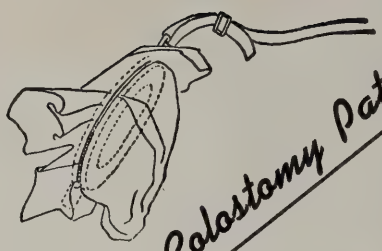
1. The Revisions Committee will recommend to the House of Delegates that the constitution be amended to add a corresponding secretary to the elected officers.

2. At the request of the president, Mrs. Paul A. Davis, a special committee on archives was established.

3. The Nurses' Scholarship Loan Fund, inactive during the war, was revived. Applicants previously recommended by the Ohio State Nurses Association, may now be recommended by any approved school of nursing having an average of 100 beds. Repayment of loan must start not later than one year after completing nurses training.

4. Adoption of the state auxiliary emblem will be deferred until approved by the Advisory Council.

5. The historical committee suggested that



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each county auxiliary keep an accurate and up-to-date record of activities.

6. A special committee for post-war planning was inaugurated to distribute medical insurance prepayment literature.

CLINTON

Members of the Woman's Auxiliary to the Clinton County Medical Association met at the General Denver Hotel, Wilmington, October 1 for luncheon and program.

Mrs. Kelley Hale, president, conducted the business session, when the auxiliary went on record as approving the proposed Clinton Memorial Hospital.

Mrs. James L. Boyd, R. N., was guest speaker. Mrs. Boyd told of her recent visit to the Dr. Watson Hospital in Pittsburgh and the treatment of infantile paralysis there.

Reported by Mrs. E. D. Peele, publicity chairman.

MARION

Establishment of a new nurses' residence will be a project of the Woman's Auxiliary to the Marion County Academy of Medicine this year.

The first step towards financing the auxiliary's project will be the opening of a "Thrift Shop" in the downtown business section, which will sell used clothing and other household articles. The auxiliary members are planning to operate the shop, turning all proceeds over to a fund for a new nurses' residence. Mrs. C. W. Smith, pres-

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Four Weeks Course in General Surgery starting November 4.

One Week Course in Thoracic Surgery starting November 25.

GYNECOLOGY—Two Weeks Intensive Course on dates to be announced.

One Week Personal Course in Vaginal Approach to Pelvic Surgery starting November 25.

MEDICINE—Two Weeks Intensive Course on dates to be announced.

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ident, and Mrs. Harold K. Mouser, program chairman, are sponsoring this worthwhile project.

On October 2 members of the Marion County Academy and the auxiliary met for dinner and program at the Hotel Harding, Marion.

Speaker for the occasion was Dr. Jonathan Forman, Columbus, who discussed the early history of medicine leading up to the present day.

Mr. Frederick Lacey and Mr. Alan Cleveland presented several musical numbers. The occasion inaugurated the joint meeting of the two organizations which will become an annual event.

American Academy of Dermatology and Syphilology Meeting

The fifth annual meeting of the American Academy of Dermatology and Syphilology is scheduled for Cleveland, from Saturday, December 7 through Thursday, December 12, Dr. Earl D. Osborne, secretary of the Academy, 471 Delaware Ave., Buffalo, N. Y., has announced. This will be the first meeting of the group since December, 1941.

The principal sessions will be held at the Statler Hotel with daily symposia at the Allerton Hotel and teaching clinics at Cleveland City Hospital Monday, Tuesday, and Wednesday of the convention week. There will be an extensive scientific and commercial exhibit held in connection with the meeting.

Most special lectures, special courses, and symposia will be presented on the first four days of the week, beginning December 9. The annual banquet will be held Wednesday night of the convention week. Dr. Harold N. Cole, Cleveland, is general chairman for local arrangements.

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JONATHAN FORMAN, M.D., *Editor*

CHARLES S. NELSON, *Managing Editor—Bus. Mgr.*

GEORGE H. SAVILLE, *Asst. Managing Editor*

HART F. PAGE, *News Editor*

Transpleural Resections of Esophagus and Stomach for Esophageal Obstruction

FREDERICK R. MAUTZ, M. D.

THERE are three lesions that account for most of the obstructions of the thoracic esophagus. In order of the frequency of incidence in the general population, these lesions are: Primary carcinoma of the esophagus, carcinoma of the cardiac region of the stomach with involvement of the lower esophageal wall, and fibrous strictures due to peptic ulcer of the esophagus, or swallowing of corrosive substances. There is now a reasonable direct surgical approach to these lesions. The affected area can be excised with re-establishment of the continuity of the gastro-intestinal tract by anastamosis of the proximal end of the esophagus to the mobilized stomach. This fact brings these various lesions together for this discussion.

It is approximately 40 years since the first surgical attempts to remove the thoracic esophagus were made.[1,2] Such names as Sauerbruch, Völcker, Kümmel, Zaaijner, Torek, Eggers, and others, were associated with these early operations. Some degree of success was attained by these pioneers in isolated instances but their good results were so few as to offer little to the large group of patients suffering from malignant obstructions of the esophagus. The patients with benign strictures, of course, had a better outlook as long as the strictures were penetrable and therefore dilatable. With the advent of newer methods of radium and roentgen ray therapy, there was great hope that this approach would offer a solution for the management of malignant obstructions. However, except for an occasional favorable response, radiation therapy has little to offer to the patients with malignant esophageal obstruction.

Palliative gastrostomy alone has gained little favor in malignant obstructions since it serves only to prolong a patient's misery. In other words, up until the present time, patients suffering from carcinoma of the esophagus could look forward to nothing, either in the way of palliation or cure of their disease. The principal reason for discussing these lesions which the average doctor perhaps would consider rather uncommon, is that at present the frontiers of surgery have been extended[3,4] so as to offer about 50 per cent of the patients with malignant obstruction of the esophagus an excellent chance of a reasonable period of relief of symptoms and a definite probability of occasional cures, and to

The Author

● Dr. Mautz, Cleveland, Ohio, is a graduate of Western Reserve University School of Medicine, 1933; diplomate, American Board of Surgery; fellow, American College of Surgeons; member, American Physiological Society; assoc. member, American Assn. for Thoracic Surgery; asst. surgeon, University Hospitals of Cleveland; asst. prof. of surgery, Western Reserve School of Medicine.

Dr. C. C. R. Jackson, Otolaryngologist at University Hospitals of Cleveland, performed the esophagoscopic examinations on the patients in this series.

Presented before the Section on Surgery at the Centennial Anniversary Meetng of the Oho State Medical Association at Columbus, May 7-9, 1946.

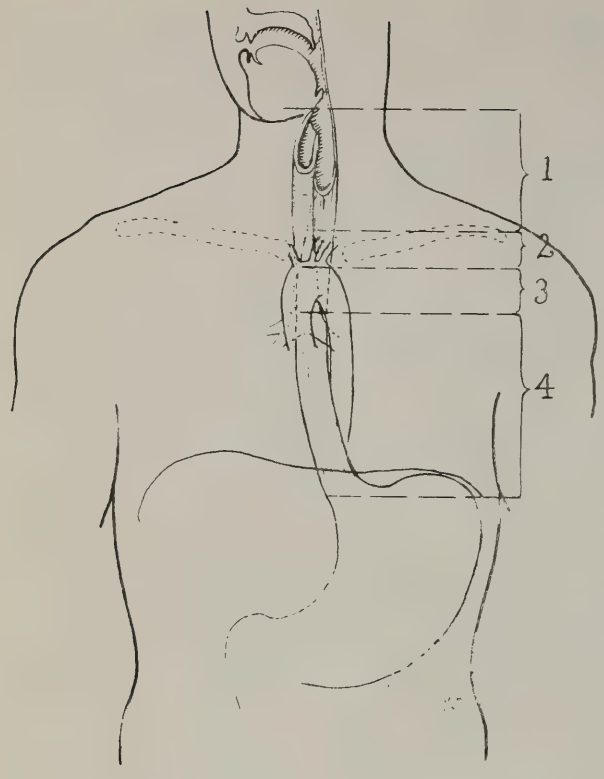


Fig. 1. Anatomical relationship of esophagus to other structures in the neck and thorax.

offer to selected cases of benign strictures and other benign obstructive lesions, a new and perhaps better approach to permanent relief of their trouble.

A number of important developments have occurred in the last decade which have been largely responsible for the improvement in results of esophagectomy for esophageal obstruction.

1. The general problems of the pathological physiology of a prolonged transpleural operation have been gradually elucidated. Without a doubt many such procedures were, in the earlier days of thoracic surgery, associated with marked disturbances in respiratory function which interfered with the technical procedures of the operation and prevented a smooth postoperative recovery. Much had to be learned about the effect of the drugs used for premedication and of anesthetic agents upon the respiratory mechanism. Later, the use of intermittant positive pressure to produce artificial pulmonary ventilation during open pneumothorax procedures greatly simplified the technical problem of transpleural operations.[5] It is possible by this means to maintain any desired degree of pulmonary ventilation in the presence of either unilateral or bilateral pneumothorax. In fact, a slight degree of hyperventilation, enough to slightly reduce the Co_2 content of the arterial blood, results in controlled breathing by gradually abolishing the respiratory effort.

If properly executed, controlled breathing is restful to the patient, removes any need on the part of the surgeon to hurry with a transpleural procedure, and makes at least some of the operations technically as easy, if not easier than, abdominal operations.

The ability to replace blood lost during an operation, with refrigerated citrated blood from a Blood Bank, is obviously very helpful, while a knowledge of the dangers of excessive intravenous administration of saline or other crystalloid solutions helps avoid artificially created postoperative problems.

2. A more complete understanding of the role of malnutrition in relation to surgical risk[6] has paid greatest dividends in patients with esophageal obstructions. Many of these patients have had a very low food intake for weeks prior to admission and have shown extreme weight loss and signs of protein depletion. Every patient who is to undergo a major operative procedure must have sufficient preoperative feeding of adequate amounts of proteins, carbohydrates and vitamins to make up for deficits and restore body reserves if the patient is to withstand the procedure and avoid serious postoperative infections of lungs, pleura and wound. Due to the obstruction of the upper gastro-intestinal tract, it is frequently necessary to resort to special diets, intravenous feedings, jejunostomy or gastrostomy feedings. In instances of extreme depletion, two weeks or more of such preparation may be necessary, but such time spent invariably pays dividends in the form of smooth and rapid postoperative recovery.

3. Sulfa drugs and penicillin, especially the latter, have played a very important role in the management of transpleural resections of the gastro-intestinal tract, in neutralizing postoperative pleural infection. Penicillin is particularly effective in combating infection due to the streptococci and staphlococci commonly found in the upper gastro-intestinal tract, as a result of the proximity to the upper respiratory tract.

I wish to briefly summarize our experiences at University Hospitals in resections of the esophagus. During the past four years, we have been attempting resections on practically all patients with malignant obstruction. Gastrostomy alone has been abandoned as a palliative procedure. The surgical problem varies with the level of the lesion. For the purpose of this discussion, four zones will be considered, **Fig. 1.** In lesions located in Zone 4, a satisfactory technique is well established, **Fig. 2.** The esophagus is approached through a left posterior thoracotomy, removing practically the entire ninth rib. The esophagus is mobilized at the site of the obstruction and sufficiently above to permit anastamosis with the mobilized stomach. The diaphragm is opened in an anterolateral direction and the stomach is mobilized by dividing ligamentous attachments to greater and lesser cur-

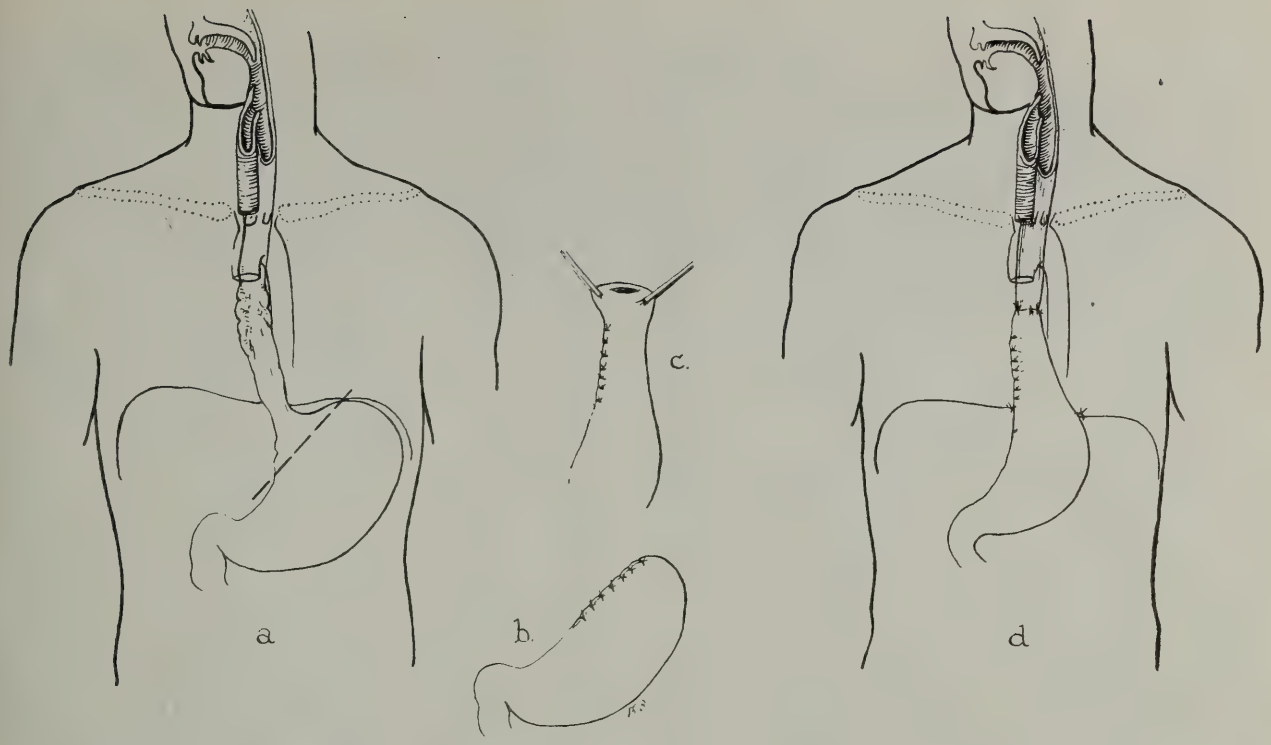


Fig. 2. Diagramatic representation of the various steps in the transthoracic resection of the lower esophagus with esophagogastrostomy.

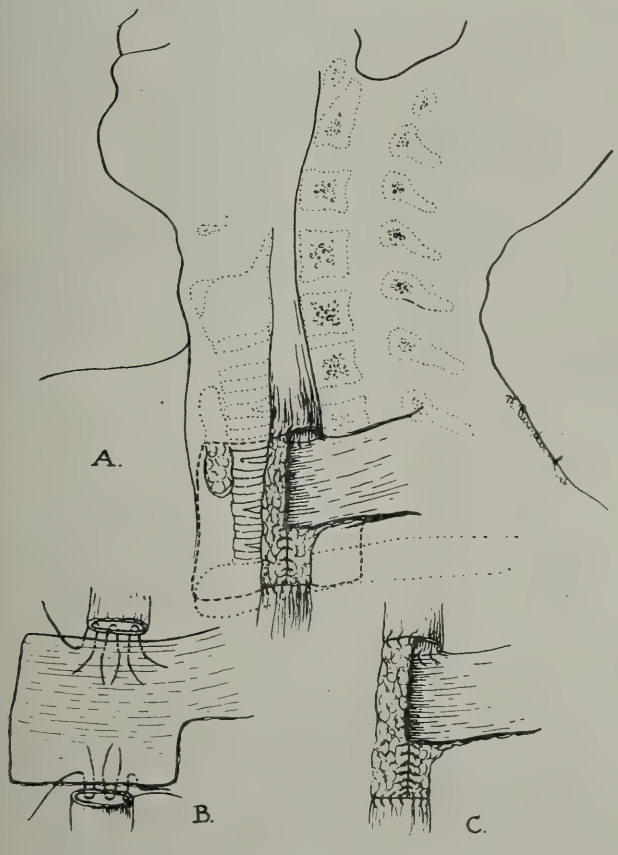


Fig. 3. The operative procedure for transcervical esophageal resection, as exemplified in Case 10.



Fig. 4. Tracing of second oblique roentgenograms of Case 9, showing site of lesion and anastamosis.

vatures until the fundus can be drawn up to the proximal esophagus without tension. This is a good cancer operation since it is possible to remove the primary lymph nodes along the upper lesser curvature of the stomach.

It is interesting to recall that only a few years ago it was considered that esophageal anastamosis would be impossible due to the fact that the esophagus has no serosa to seal an anastomosis or no submucosa comparable to the

SUMMARY OF PATIENTS THAT SURVIVED RESECTION OF ESOPHAGUS

Case No	Sex-Age	Duration of Symptoms Weight Loss	Site	Operation	Pathological Diagnosis	Results
1	Male 56	10 months W.L.—40 lbs.	Upper Zone 4	Torek	Squamous cell carcinoma, partially differentiated. Regional node metastases present.	Good—Gained 20 lbs. and in good health for one year. Tolerated rubber tube esophagus fairly well. Died 1½ years due to metastases.
2	Male 47	3 weeks W.L.—20 lbs.	Lower Zone 4	Transpleural resection with esophagogastrostomy	Fibrous stricture probably the result of a peptic ulcer of the esophagus.	Excellent—Complete relief to date (3 years).
3	Male 63	2 months W.L.—22 lbs.	Lower Zone 4	Transpleural resection with esophagogastrostomy (Operated by Dr. Frank S. Gibson)	Squamous cell carcinoma, well differentiated. Regional node metastases present.	Good—Excellent immediate results. Died at home of acute illness 6 months, probably not from metastases.
4	Male 62	6 months W.L.—50 lbs.	Center Zone 4	Transpleural resections with esophagogastrostomy	Squamous cell carcinoma, partially differentiated. Regional node metastases present.	Poor—Improved for 3 months, then gradually declined from metastases.
5	Male 65	8 weeks W.L.—35 lbs.	Zone 3	Torek	Squamous cell carcinoma, well differentiated. Regional node metastases present.	Poor—Died 3 months of combination of metastases and starvation.
6	Male 50	4 months W.L.—70 lbs.	Fundus stomach Lower + Zone 4	Transpleural esophagogastrectomy. Anastamosis lower esophagus to pyloric region stomach.	Adenocarcinoma. Regional node metastases present.	Poor—Due to extent of metastases.
7	Female 67	2 years W.L.—25 lbs.	Lower Zone 4	Transpleural resection with esophagogastrostomy	Squamous cell carcinoma. Partially differentiated. Regional node metastases present.	Excellent—Follow-up to date only four months.
8	Male 61	8 months W.L.—30 lbs.	Upper Zone 4	Left transpleural resection with esophagogastrostomy	Squamous cell carcinoma. Well differentiated. Regional node metastases present.	Excellent immediate result (recent case).
9	Male 62	2 months W.L.—40 lbs.	Junction Zones 3 and 4	Left transpleural resection with esophagogastrostomy	Squamous cell carcinoma. Undifferentiated. Regional node metastases present.	Excellent immediate result. Died 3rd week of hemorrhage. Aorta perforated into G-I tract at anastomosis.
10	Male 61	2½ years W.L.—25 lbs.	Lower Zone 1	Transcervical resection with reconstruction of defect from pedicle of skin.	Squamous cell carcinoma. Undifferentiated. Regional node metastases present.	Excellent immediate result (recent case).

lower gastro-intestinal tract to give strength to a suture line. Neither of these ideas have proven to be correct.

Lesions in Zone 1 can be removed by a transcervical approach, Fig. 3.[7] As a preliminary to the resection, a pedicle of skin is elevated from the anterior neck and chest wall of the proper size and shape to replace the segment of esophagus that must be removed. When the esophageal segment is resected, the skin tube is sutured in place, leaving the pedicle intact until a later date, at which time it can be divided and the cleft in the neck closed. Any raw surface left by removal of the skin flap can be covered with a split skin graft at the time of the resection. Primary lymph nodes can be treated by neck dissection or irradiation.

Lesions in Zones 2 and 3 offer a more difficult technical problem. At present it appears that lesions in Zone 2 can be reached by extending the transcervical operation and making a longer skin tube. Lesions in Zone 3 have been successfully removed through a left transpleural approach and anastamosing the gastric tube anterior and above the aorta to the proximal esophagus at the region of the pleural reflection.[8]

Our own results up to the present time are summarized in the table. There were four deaths from operations, not listed in the table, in patients with extensive local malignancy. There were no operative fatalities in the patients with intrinsic lesions which were considered operable. It will be noted that all the carcinoma cases in this series had regional lymph node metastases. It is believed, however, that when the series has been extended to a significant number, that occasional cases will be found with minimal or no metastases, especially when these cases are diagnosed soon after the development of symptoms. It should be pointed out that any patient with difficulty in swallowing solid food on whom an accurate radiographic diagnosis can not be made, should be esophagoscoped. Sometimes the early symptoms are not very striking and the patient unconsciously changes his diet so as to avoid swallowing the solids that tend to cause obstruction at the site of the lesion.

SUMMARY

It is now technically possible to resect obstructive lesions of the esophagus at any level. The mortality associated with these operations is almost entirely in the patients with malignant obstructions in whom the lesion has extended beyond the limits of the esophagus. Earlier diagnosis would reduce the number of these cases but as Torek pointed out in 1915: "Patients afflicted with carcinoma of the esophagus consult their physician mainly on account of one solitary symptom, the inability to swallow food, and that is a late symptom." However, several patients in this series could have been diagnosed and operated upon much sooner. The direct surgical approach to all localized obstructive lesions of the esophagus is now well established and should be the method of choice for dealing with these lesions. Earlier institution of such treatment in malignant obstructions will undoubtedly result in improved followup, and will be a worthwhile procedure in approximately 50 per cent of such patients. It is only by surgical exploration that the operability of many of these lesions can be determined.

BIBLIOGRAPHY

1. Torek, Franz: The Operative Treatment of Carcinoma of the Esophagus. Annals of Surgery, 61:385, 1915.

2. Eggers, Carl: Experiences with Carcinoma of the Esophagus. Jr. of Thoracic Surgery, 2:229, 1933.

3. Churchill, E. D., and Sweet, R. H.: Transthoracic Resections of Tumors of the Stomach and Esophagus. Annals of Surgery, 115:897, 1942.

4. Garlock, John H.: Causes of Mortality Following Radical Resection of the Esophagus for Carcinoma. Jr. of Thoracic Surgery, B:415, 1944.

5. Mautz, F. R.: Physical Considerations of Thoracic Surgery. Handbook of Medical Physics, Year Book Publishers, Inc., 1st Ed., 1944.

6. Studley, H. O.: Percentage of Weight Loss: A Basic Indicator of Surgical Risk in Patients with Chronic Peptic Ulcer. J.A.M.A., 106:458-460, Feb. 8, 1936.

7. Wookey, Harold: The Surgical Treatment of Carcinoma of the Pharynx and Upper Esophagus. Surg., Gynec. and Obst., 75:499, 1942.

8. Garlock, John H.: Causes of Mortality following Radical Resection of the Esophagus for Carcinoma. Jr. of Thoracic Surgery, 13:415, 1944.

Grandfather's Vitamins

We have all heard this: "How did we manage to get along before we knew about vitamins and had all of these new fangled notions about food? What was good enough for grandpappy is good enough for us!" The point is this: while grandpappy was living to the ripe old age of ninety, thousands of potential grandpappies were filling small and untimely graves in community churchyards. Many of the health hazards of that day were unrecognized, but this made them no less dangerous. Knowledge releases us from the rule of chance and gives us a rational guide to health and longevity.—Walter Wilkins, Surgeon, U.S.P.H.S., Mississippi Doctor, April, 1945.

Exercise in the Aged

In the care of the elderly, physical exercise usually becomes a problem. My personal belief is that the elderly should continue in their normal habits, only changing when the years put definite limitation, not theoretical limitation. I have seen mountain climbers of 80 and again those whose only exercise is conversation and smoking. But a reasonable amount of walking, if one is used to it, is probably better than sitting constantly at home, in the office, or in the club. —Roger I. Lee, M.D., Boston; The Mississippi Doctor, Vol. 24, No. 2, July, 1946.

Schizophrenia in Children

HENRY C. SCHUMACHER, M.D.

IN recent years there has grown up a considerable literature on schizophrenia in children and it has been ably reviewed by Lutz,[1] Lay,[2] and Bradley.[3] Accurate figures, however, as to the incidence of this disorder in childhood are not available. One reason for this is the failure of many authors to delimit the age of childhood. Another reason stems from the variability of diagnostic standards, and a third reason is the belief of many psychiatrists that schizophrenia can not occur before puberty. As a result, schizophrenia in children is still listed as among the rare mental disorders of this age-group. In this paper I am reporting only cases occurring in children before their thirteenth birthday.

Case 1. First seen July 25, 1945, white female, born June 2, 1941, older of two, her sister being 1½ years younger than she. Mother was nauseated and vomited much during the first five months of the pregnancy. Delivery was by forceps and the child was a "blue baby". In general, child is a big eater. Teething commenced early. At 14 months child was walking. Toilet training was difficult, child continuing to wet herself till 3 years of age.

Complaint at time of referral: Mother fears child is showing increasing retardation and is failing in her social adjustment. She states child was quite normal till about one year ago. Mother feels that the retrogression is due to food allergy in that the child is said to be sensitive to egg yolk, chicken, and beef. At times child will trip and fall badly and seem to have "muscular fatigue". Child spoke fairly well at 2½ years of age. At about this time, parents scolded her for something and child did not speak to anyone for the following 17 days. Then when she began again her ability had retrogressed considerably and now she does not speak better than a 2½ year old child.

Child does not get along well with any children. She was in nursery school earlier in the year but she would not join in the group in any respect. She masturbates openly. When she gets angry, she becomes rigid and throws herself over backward. Although a quiet, seclusive child, she will have long whining spells and make "terrible noises". When crossed she is exceedingly negativistic and irritable. Now she uses many neologisms. Much of her behavior is ritualistic and bizarre and much of the time she seems preoccupied with her own world. If she is taken for an auto ride she keeps repeating over and over "red light, green light".

Follow-up: The patient was seen but once following the original examination, the parents refusing to cooperate further in psychiatric treatment.

Physical examination was not done in the Center since child is under the care of a competent pediatrician who reports no abnormalities except allergy to the foods noted above.

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The Author

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Psychological examination was done on July 25, 1945. Revised Stanford-Binet, Form L gives child an I. Q. of 77. The picture is one of a wide scatter of abilities. There was extreme difficulty in following verbal directions even at this early level. She was quite distractable and often became irritable and tended to refuse items in the test. Her inability to follow verbal directions is striking. Frequently the first repetition aroused no change in facial expression nor did she show in any other manner that she had heard the directions. With two or three repetitions she could usually follow directions if her response was to be non-verbal.

Family History: Parents were not sufficiently cooperative to give a detailed family history. However, the father is a retiring man of few social contacts. The mother is definitely the aggressive and dominant partner. Discipline has been erratic.

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Case II. First seen on May 31, 1940, a white male, born August 27, 1934, the elder of two children, his brother being about two years younger. Pregnancy was uneventful but it was a breach presentation and delivery. Other than a wry neck, which has been corrected through exercises, no other injuries were noted. Nursing and eating are reported as normal. There have been no sleep disturbances. Toilet training was difficult and was unsatisfactory until he was about 2½ years old. He smeared feces on himself, his crib, and the walls. He walked at about one year. He began to use words at one year or a little earlier. The mother spoke of the boy becoming easily sulky and pouty from as far back as age 2. Mother stated she had reared him according to a schedule.

Complaint at time of referral: The boy was brought in at the suggestion of a visiting teacher because of his behavior in school, and the school report was as follows: The kindergarten teachers have had a great deal of trouble with this child since he started kindergarten. The parents are passively concerned in his welfare and the mother was surprised that he was not getting along well in school. The child is continually talking about how tough he is and tells how he is always hurting someone, breaking windows, shooting somebody, stabbing someone, having his dog bite someone, etc. The teachers report that he never enters into any activities that require

playing with or dancing with other children. In fact, he never talks in a conversational way with other children. As long as the teachers say nothing to him, he will sit at a table and amuse himself by drawing or painting, even when the other children have joined in a circle for a story or for some other activity. If a teacher asks him to enter in with the rest of the group, he refuses and becomes negativistic. If they insist, he will become angry and go into a tantrum throwing his shoes, etc. He crawls over the table and runs about the room.

On a home visit the visiting teacher learned that the child at age 3 had a fellatio experience at the hands of a 13-year old boy.

Follow-up: An attempt was made to work with the parents but neither the father nor the mother were interested in care. However, on April 14, 1944, the mother called stating that she was anxious for an appointment as soon as possible. She indicated that due to some physical condition, she would not be able to come in alone but that her husband could bring her in some evening. The case was reopened May 17, 1944. The mother still denied that the boy was in any sense difficult at home but admitted that he was a problem at school. He recently had thrown a scissors at a teacher. The school reported a continuance of the behavior noted above. The boy told the school psychologist that he threw the scissors at the teacher because his dog was poisoned. He also talked about having spells when he got hot and does bad things. The school psychologist reported him to be unstable, flighty, and emotional. His scholarship was poor. His present teacher reported that he didn't mix with the other children and stayed indoors during recess periods. She talked about his fantasies and that if he were not permitted to carry out aimless activities, he would fight and try to carry out whatever he seemingly had in mind. Again little was accomplished in working with the parents. The child was refused at summer play school because of his uncooperativeness. Later a placement was made at a summer camp. Here he drank some mercurochrome when reprimanded for running away.

He was seen by a psychiatrist in the Center on August 8, 1944. The notes state: The total picture is one of bizarreness. He would roam about the room, just look at things casually and make pointless remarks. Because his behavior was so disturbed, arrangements were made to admit the boy to the Children's Aid Society Study Home. He was admitted on March 6, 1945. The following account is taken from the notes of the house staff:

"He is quite an impulsive youngster. This morning he decided to run wild all about the building. When I talked to him about it he got very angry and wouldn't answer. About ten minutes later, I found him entirely hidden in his wraps in his locker. He sat there till noon.

"He shows many inhibitions in eating. He is still having trouble about washing. He often comes out with rather disorganized, incoherent remarks that have nothing to do with the situation at hand.

"There is a peculiar intenseness about him at all times, an unnatural shine in his eye, a tremor in his voice, and a shaking of his hands. There is also an effeminate quality in his walk and in his carriage.

"He is a lonesome boy as he is not able to make friends. He has behaved very peculiarly ever since Christmas. He gets all stirred up on some subject, such as his billfold not folding just evenly, and goes on and on until he becomes rigid.

"His behavior is so often unrelated. When we are having fun making something he wants to fly a kite. If we fly a kite he goes off on a tangent about marbles."

His teacher reports as follows: His reading is at second grade level but he is doing fourth grade arithmetic. He shows a great deal of agitation in the school room. A great deal of the time one finds him standing looking out the windows or jittering around when he is supposed to be seated. He still has a wild vacant stare. When talking to a person he is rarely able to state his wants in a definite sentence but hems and haws about and makes little sense at all. He certainly does not seem to be in the classroom but somewhere else during three-fourths of the classroom time. Recently he was coloring a large diamond on his arm. When the pen was taken away from him he showed intense signs of irritability. I can see little improvement in this boy so far as the classroom work and activities are concerned.

Physical examination was essentially negative.

Psychological examination: Revised Stanford-Binet, Form M done on May 31, 1940, gave him an I. Q. of 93. The Rorschach at this time showed him to be a child whose feelings are easily stimulated. There was definite indication of uncontrolled expression of feeling and fantasy with slightly anxious content.

A Rorschach under date of August 21, 1944, notes that the responses give some indication of above average mental ability although the actual production is of somewhat uneven quality. There is a creditable degree of originality in content. There are indications of a great deal of anxiety and conflict. Some degree of instability is shown and the lack of development of satisfying inner life. One could expect impulsive emotional reactions from this child. No symptoms of organic brain disease were in evidence. The Revised Stanford-Binet on May 25, 1944, gave him an I. Q. of 109, and there was a rather wide scatter. The Arthur Performance Scale, Form I given on November 14, 1944, credited him with a mental age of 14 years 3 months.

Family History: Mother has been diagnosed as suffering from multiple sclerosis. Father has a violent temper. Mother calls them his black moods. Neither parent saw patient as a problem at home.

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Case III. First seen on March 12, 1943, a white male, born on February 28, 1936, the elder of two living children, his sister being 3½ years old. Pregnancy was normal, but it was a breach presentation and delivery. The head was bruised but the doctor stated that there was no brain injury. Nursing was uneventful and no difficulty was noted with weaning. He was considered "a lazy baby" and did not begin to walk till 16 months of age. He began to use single words at the age of 12 months. At 15 months he no longer wet himself except for an occasional accident at night or when ill with a cold. First tooth was cut at 7 months. In infancy he was a good sleeper. There is no history of a sudden change in behavior although his mother is inclined to feel it became steadily worse since the birth of his sister. He has had measles and chicken pox since entering school.

Complaint at time of referral: He eats poorly. He picks his food with his fingers and procrastinates much over eating. Frequently, he holds food

in his mouth and later spits it out. He speaks very slowly and finds it so difficult to express himself that his mother gets tired of waiting. He stammers badly at times. He is frequently incontinent. He goes to the toilet frequently and masturbates but does this on other occasions also. His sleep is disturbed as the result of nightmares. He has many fears.

He spends most of his time indoors alone indulging in daydreams. He has a vivid imagination and "often screams from the nervous tension created by his imaginings". He becomes extremely sullen and stubborn when crossed, as for example, when asked to do something or to go out to play or whenever he is interfered with. He is cruel to his sister. He has choked her and poked her with scissors. He does not play with her.

He entered kindergarten at age 5. The principal of the school stated the boy has been peculiar ever since he entered. His motor coordination was very poor. He was described as exceptionally shy and retiring; an introvert in a shell of his own. He never played with the other children although they were protective of him. He spends most of his time staring and daydreaming.

Follow-up: Because of the mother's condition little was accomplished in changing the parental handling of the child. In August, 1943, the boy was placed in a well managed summer camp primarily to obtain objective reports on his behavior. The following is an abstract of the counselor's notes: Physical activity was shunned. He had no interest and his coordination was very poor. He was highly imaginative and would delight in living completely within his imaginative world. There is no reality in his life and he desires none. Extremely negativistic. He either refuses to do or does the opposite. Terrifically slow in eating and refuses many foods. When crossed, acts in a horrible manner.

The parents were persuaded to place the boy at the Children's Aid Society, a study and treatment institution under the professional supervision of the staff of the Cleveland Guidance Center. He entered the institution on November 16, 1943, and is still there. The following quotes are from the notes of the house staff:

"Boy is an isolationist. He is usually alone and other children pay no attention to him. When he is crossed, he pouts and stamps about. When he was asked to go outdoors, he cried vigorously and was mighty mad. He is soiling and wetting himself at school. He is a slow eater, holds his food in his mouth for hours. His walk is very childish. He holds himself so tense, at times he twitches. He spends most of his time just daydreaming. He will play with blocks and will cut out things. He also collects scraps of paper, string, and stones. Occasionally he skips around the room in a girlish, feminine manner." This boy, however, has made some improvement in this controlled environment. The March note reads: "Boy seems to be improving and getting along much better. Likes to play outdoors more. Doesn't stand around. He is losing his twitching." The school teacher reports: Boy is doing about third grade work (he was a non-reader when he entered school at the institution). He seems to be coming out and exerting himself a little more with the group. He is doing his part in trying to become accepted by them. When he first came in you could hardly hear him speak. Now when he reads, you can hear him all over the room. However, he will often sit and dream rather than do the work that he is supposed to be doing no matter what it is. His best work is in art and he is being permitted to go to art classes.

Physical examination revealed vision 20/70 in the right eye and 20/30 in the left. Corrected to normal with glasses. Cervical adenopathy. Many teeth showed severe caries. Left testicle undescended. Penis is invaginated. He was given antuitrin-S one cc. 3 times a week from March 14, 1945, to May 2, 1945, when physical examination revealed left testis was in scrotum. It was thought that coincident with this medication there was some improvement in his general behavior.

Psychological examination: The Revised Stanford-Binet, Form L given on March 12, 1943, gave him an I. Q. of 115. There was an unusually wide psychometric scatter. On January 29, 1945, he was given the Arthur Performance Scale, Form I and obtained an I. Q. of 108.

On March 21, 1946, he was given Form M of the Revised Stanford-Binet and earned an I. Q. of 101. He passed all tests at the 8-year level and failed all tests at year 13. Most tests failed were memory tests. His usual response to sentence memory was to insert new or unrelated words. In the Rhymes Test he rhymed date with late and then said plant. A significant response pattern was noted for Similarities. Three things, snake, cow, and sparrow are alike because "they can make noises and talk to each other". In some instances the problem would be forgotten because he became so engrossed with his own thoughts.

He was given another Rorschach test on March 12, 1946. This showed him to be a boy who is potentially of good intelligence but who at the present time is too much absorbed in his own thoughts and too prone to attend to the minutia of life to function well in reality. Basically he is a child far more given to living within himself then to interaction with his environment. He is made anxious by the arousal of feeling and when he is upset he responds to this with strict inhibiting of feeling or in compulsive activity. This is balanced somewhat by his ability to work things out in fantasy.

Family History: The parents are native Americans whose families settled in this country in the 17th century. The father, age 33, is described as a small, thin, rather meek looking man. He was reluctant to talk and saw no problem in his child's behavior apart from the school problem. His wife describes him as a very dependable and stable person who is quiet, likes to do his own thinking, and just isn't too sociable. He feels the child is as happy as he is and he doesn't think it wise to make a mountain out of a molehill. The mother, age 30, is a short, plump woman. Her conversation is often incoherent and hence difficult to follow. She lacks self-confidence and is anxious lest the boy may have inherited her own emotional instability. She had a "nervous breakdown" shortly after finishing high school. She was hospitalized shortly after the death of her third child two years ago. The diagnosis was paranoid type, dementia praecox. She was discharged into the custody of her husband. Her discipline has been overprotective.

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Case IV. First referred on February 17, 1941, is a white male born July 2, 1933, the younger of two children, his sister being 20 months older. Mother states she was "nervous" during her pregnancy and had considerable nausea and

vomiting. Birth was easy. He was not a good baby in that he cried a lot. He did not feed well in the early months. He had four teeth at one year. He walked at 11 months. At one year, he said a few words. He had whooping cough, chicken pox, and measles in the first three years of life and he was always a quiet, though restless, child in his early years.

Complaint at time of referral: Mother's first statement was, "he has a great imagination". He not only tells himself stories but tells "great lies" to other members of the family. She said he had but one interest and would spend his entire time at it if allowed, namely, bumping his toy automobiles together and wrecking them. During this play, he talks to himself and seems to be lost to this world. He also carries on conversation with imaginary people. He does not play with other children to any extent.

He has difficulty in falling asleep in that he is so occupied talking to himself. He is fidgety and flighty in his general reactions. The school reports that he is achieving nothing. He does odd and peculiar things. While marching into church he will suddenly dart from the line and annoy other children. In school during the class hour he runs up and down the aisles making noises. He curses, he has temper tantrums, and throws whatever is handy. Recently he suddenly stood up and flapping his arms cried out, "Cuckoo, Cuckoo".

Follow-up: An attempt was made to work with both the parents and the child. However, little was accomplished beyond the parents being more accepting of the situation. In the Fall of 1945 the case was reopened at the request of the mother and the school. In many ways the child was in a worse state than before. The mother reported that he now snarls at her whenever he is asked to do anything. He now wets the bed unless gotten up. He is more irritable in his behavior with all members of the family. The mother stated she now realized he was in no sense a 12-year old boy in his behavior. He would go unwashed and dirty if she didn't clean him up. In school he is accomplishing nothing.

Physical examination done on March 24, 1941, was essentially negative. November 27, 1945, he was a few pounds overweight but he gave the impression of being an immature boy. His skin was soft and of poor elasticity. His hands and feet were cold. Dr. E. M. Zucker did an electroencephalographic study on February 27, 1946. He reported as follows: "This electroencephalogram is probably normal. The only suggestively positive finding was the minimal amount of moderately slow activity from the frontal regions but this can not be regarded as definitely abnormal at 13 years of age. There is no definite evidence of an idiopathic convulsive disorder or focal organic lesion of the cortical areas examined".

Psychological examination: The Revised Stanford-Binet Test, Form L, done on March 14, 1941, credits patient with an I. Q. of 83. Basal age year 5 with successes through year 8. The Arthur Performance Scale I. Q. was 77.

On November 15, 1945, he was retested. Upon entering the examining room he suddenly said, "I can't tell time". He was quite babyish and immature in his manner. Much of his talk and language is baby talk. He says, for instance, "betause" instead of because or "Him didn't come". The level of cooperation was fairly low and he did not put forth much energy. He made random remarks about snakes and then began to fantasy about them. On the Revised Stanford-Binet, Form L, he earned an I. Q. of 70. The basal age was 6 with successes through year 10.

The Rorschach test was given him. The performance on this test was far more spasmodic than the performance on the other tests. Many of the concepts were distorted and disturbed. There was disturbance and confusion concerning sex. The picture is not a banal one found in a dull child but rather is fraught with much underlying anxiety, with many bizarre fantasy concepts and a severe disturbance in sexual and emotional situations.

Family History: There is no history of mental disease in this family. Both parents are rather inadequate and immature. Discipline has been overprotective.

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Case V. First seen on June 6, 1945, white male, born May 2, 1935, the youngest of three siblings and the only boy. Pregnancy was quite uneventful and delivery was normal although forceps were used. Feeding history is negative throughout infancy.

He began to walk at 13 months and to talk at 18 months. However, it was not until he was three years old that he could make sentences. Previous to that time he tended to repeat what someone else said. He cut his first tooth at 9 months. He never wet or soiled himself by the time he was two and a half years old. When he was still a very young baby he showed signs of being quite nervous. When anyone entered the room after he had been put to bed, even after he was asleep, he would wake up and stand up in bed.

Complaint at time of referral: Parents were at a loss as to what to do next. The child has been a problem since the age of three. Mother was concerned because of his negativism, his bizarre behavior, and because of his speech disturbance. He is solitary and has no interest in joining the group. He talks and mumbles to himself. This past year he was enrolled in a school for retarded children in another state. He was placed there in the hope he would improve in his social adjustment. The director of that school felt his behavior was not feebleminded but psychotic.

Follow-up: Since the family could find no suitable placement they asked that he be admitted to the Children's Aid Society Study and Treatment Home. He entered January 7, 1946. The following notes are abstracted from the reports of the house staff:

"He is solitary. Wanders about in an aimless way. He eats with a spoon and uses it like a shovel. He has to be shown how to wash. He seemed to have no control over his muscles. He tried to climb the bars of the jungle gym but he could not go beyond the second bar. He was taken to the Aircraft Show. He showed extreme fear in crossing streets. Kept mumbling to himself. He was heard to remark, 'I must not talk to myself. I must talk to other people.'

"He has wet the bed. He makes a lot of noise in the dormitory. He will sit or stand and stare and make facial grimaces. When going to the bathroom, he will put paper into the toilet, pull it out, make spit balls and throw them around. He plays with blocks or bounces a ball. He has difficulty in talking. It is halting and jerky. He is tense and extremely unsure of himself. He loves to play with a stick—just shaking it. He has many rituals in walking—contortionist."

Physical examination: The extremities, both

arms and legs, seem underdeveloped. Otherwise, he is essentially normal in physical development.

Psychological examination: He entered the examination room showing many mannerisms in his walk. His attention was difficult to hold and he withdrew more and more into himself. When he left the room he made an odd gesture toward the examiner which was half affectionate and half a blow. He spoke in a jerky, stilted way and somewhat voicelessly On the Revised Stanford-Binet, Form M, he earned an I. Q. of 55. He succeeded in all tests at year 5 and failed all tests at year 9.

On the Rorschach test he showed a great deal of generalized anxiety which encroaches upon and colors his interpretation of everything so that he is not able to perform as well intellectually as one would expect for his mental age. He is quite compulsive and perseverative.

Family History: The father recalls that one of his brothers was much like this child. The mother stated that her mother had a half-brother who was never mentally right. Discipline has been somewhat overprotective.

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Case VI. First referred on July 31, 1945, white boy born October 9, 1934, the second of two children, his sister being four years older. Pregnancy was normal. Instruments were used but delivery was uneventful. Feeding was normal in early infancy. He was toilet trained at 2½ years.

Complaint at time of referral: The mother describes him as an extremely withdrawn boy whose behavior is ritualistic and compulsive. He shows a complete lack of any desire for association with children. The neighbors think him "queer".

The mother dates the beginning of his behavior difficulties from the age of three when he was placed in a nursery school. By the time he was five years old he was a most irritable child, a "bundle of nerves". He never wanted to sit down and was in constant motion. He would twist and turn. There was much facial grimacing. He began to have feeding difficulties. He wanted only a liquid and soft diet. Masturbation became frequent. He entered kindergarten at 5½ years of age. He did not want to go to school. In school he would not conform. He began to soil himself. More recently he has begun to show poor muscular coordination. He walks with a peculiar gait resembling a shuffle. He moves his arms stiffly against his sides with hands clenched so that his thumb is held rigidly against his palm. Both at home and at school he has been observed talking to himself. He shows much ritualistic behavior. He will walk in one direction a few feet, make a square turn and walk a few feet and so on. Recently he started kissing and hugging little girls.

In summer play school he was unable to participate with children even at the seven and eight-year old level. His speech is described as sterile and ideas are unrelated. He now is completely unaware of people or of his immediate surroundings, so engrossed is he in himself.

Follow-up: He has been seen at weekly intervals for psychotherapy. The psychiatrist believes he is steadily getting worse. He plays with dolls in a childish manner. His speech is a monotone. He will carry on long discussions with himself about astronomy. Mannerisms are more pronounced. It is hoped he may be admitted to the Chidren's Aid Society Study and Treatment Home in the near future.

Physical examination: The family pediatrician, on July 1, 1944, in a report to another clinic, stated the physical examination was normal. An examination done on August 28, 1945, notes him to be at maximum height for his age and about 12 pounds overweight. Fat distribution was similar to a mild Forelich's. However, examination in an endocrine clinic was negative. He was, however, given antuitrin S without improvement in his mental condition.

Psychological Examination: When he entered the room he talked in a monotonous but steady stream asking and answering his own questions. He was active, turning and twisting himself in his chair. Occasionally he was quite out of contact with the examiner. At times he was quite negative.

On the Stanford-Binet, Form M, done August 30, 1945, he earned an I. Q. of 92. His basal year was year 8 and his upper limit was year 13. He dealt very poorly with ideational material and did not grasp the verbal absurdities at any age level.

Family History: Father is an academic, passive, unsocial individual who suffers from colitis of 10 years standing. Mother is the aggressive member of the family. She has a younger feeble-minded sister. The discipline has been overprotective.

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Case VII. First referred on May 8, 1941, a white male, born May 2, 1929. He is the third youngest of eleven children. Pregnancy was unwanted but uneventful. Birth was easy and no instruments were used. He said single words at 12 months. He walked at 15 months. No feeding or weaning difficulties were encountered. He slept fitfully as an infant. He was toilet trained at 2 years of age. He had measles, mumps, chickenpox, and whooping cough all before 5 years of age.

Complaint at time of referral: The mother dates the beginning of difficulties at least 3 years ago. At about that time he began to wet himself during the daytime as well as at night. He also has been soiling himself frequently since then. Sleep began to be disturbed with much talking and nightmares in which he would scream out wildly. Thumb sucking has continued since infancy and is more frequent and persistent. His speech is less clear and distinct than when learning to talk. He now displays violent temper, screaming and striking at everyone when crossed. Runs away. His play is that of a younger child—cops and robbers—when he will be with a group, but mostly solitary. His school work, never good, is getting worse right along.

In the psychiatric interview the boy at once told of hearing voices. These disturbed him both during the day and at night. In school his attention is distracted by the voices and he has fear and worries that he can not do his work. He said this has been so the past two years. He lost himself in fantasy and jumped up in terror.

Follow-up: In view of his serious mental state he was admitted to the Children's Aid Society Study and Treatment Home. His behavior in the institution bore out all the statements made above. In addition, he complained of many vague physical pains and sensations. He constantly wanted to be alone and any interference met with violent outbursts. He ran away often after such outbursts. He expressed frequent delusions, such as his food was poisoned or there were cockroaches in it. He refused to go to school—would run and hide himself and remain

in such hiding for hours. His only interest is in art. At times he seemed to be making some improvement but it would not persist. His violent rages and destructive attacks finally made it impossible to keep him and he returned home in June, 1943.

In May, 1944, we learned of his admission to State Hospital. He has been in and out—run away—several times since then. In October, 1945, a report from State Hospital reads: "While here he was irritable, disagreeable, and destructive. Recently he visited our Out-Patient Clinic and was rather uncooperative; became cross with the doctor, went home, threw furniture around, tossed his mother's house-plants on the floor and was generally destructive, finally leaving home." The hospital intended to have him returned.

Physical examination: He was examined on May 27, 1941, and found to be a well-developed and well-nourished 12-year-old boy. He had a very slight visual defect in his right eye. Repeated physical examination never revealed any cause for his vague somatic complaints. He was feminine in appearance.

Psychological Examination: N o t h i n g was volunteered by him. He was shy and withdrawn. The Revised Standford-Binet Form L was given on May 8, 1941, and he earned an I. Q. of 99. His basal year was year 9 and he failed all in the average adult.

On January 9, 1942, he was given the Rorschach test. The responses show a boy who is at least average in intelligence but who reacts in a very immature way. He has a very active fantasy life. If it were not for this fantasy, his responses would be much like those of a depressed person.

Family History: The parents are separated. Agency records describe the father as emotionally less stable and to have less initiative than his wife. He was considered a sexual psychopath. He was interested in the Spiritualist Church and frequently went into trances and when he recovered consciousness found his clothes partially off. He was a harsh disciplinarian. The mother is very labile emotionally and lacks self-confidence. She is emotionally very dependent. The mother was protective and vacillating in her discipline. Five older children, 2 boys and 3 girls, have had stormy adolescent careers. All of them have been sex offenders. One older girl has done quite well.

SYMPTOMATOLOGY AND DIAGNOSIS

What can we deduct from these case studies? First and foremost that all forms of adaptation are involved and that pathological disturbance occurs at every level of nervous system function —vegetative, motor, perceptive, intellectual, emotional, and social.[4] All integrative functioning is disturbed, but this will manifest itself according to the developmental age of the child. It is of major importance to note that schizophrenia in children is not to be diagnosed on the resemblance of a few symptoms to those almost diagnostic in the post-pubertal age-groups. Delusions and hallucinations are rare in this age-group. Only one child, Case VII, showed such symptoms.

Symptoms vary from one age level of development to another but in all cases represent a severe distortion of the entire personality. The most common observable behavior traits are: Seclusiveness, associated with irritability if the seclusive activities be interfered with, excessive daydreaming, bizarre behavior, diminution of interests and preoccupation with interests common to younger children, sensitivity to criticism, often associated with violent outbursts, and a reduction in physical activity.[5]

Bradley[6] calls attention to Bleuler's[7] concept of primary and secondary symptoms. He points out that the primary symptoms are those resulting directly from the fundamental disturbance in schizophrenia. Withdrawal from reality is basic, and seclusiveness and daydreaming are direct evidence of such withdrawal. The secondary symptoms are the outgrowth of the child's attempt to adjust himself to an external world and are expression of his conflicts. Anxiety, fear, and guilt are such secondary symptoms.

There is but one girl in this series of cases. This is a smaller incidence than generally reported which is to the effect that schizophrenia in children may be two or three times as common in boys as in girls.[6,8,9,10,11,12]

The type of onset generally reported is either acute or insidious. The insidious onset type may show acute episodes.[13] In this series of cases the onset in general is insidious. The question is raised in the literature whether or not there is a preliminary period in the early life when the patient was free from any evidence of the illness. This series of cases would tend to show that there is such a period of freedom from symptoms. However, when one reads that long after the disease is in full bloom some parents are still unwilling to recognize any disturbance of a meaningful kind, it is not strange that it is difficult to elicit evidence of such disturbance in integration until it is severe enough to disturb the parents, often as a result of outside pressure, such as results from complete failure in school adjustment. Tramer[14] and Bradley[15] have quite conclusively shown that the more one studies details of the early development of these children, the more early personality disturbances become apparent. Kanner[16] has reported an interesting series of cases which he, however, believes to be a separate category. However, as Bradley[6] points out, it does suggest that the schizophrenic reaction may merely express an exaggeration of the previous personality characteristics.

The diagnosis of schizophrenia in childhood is confirmed by the presence of the symptomatology enumerated above, and the ruling out of other disorders. Bradley[6] lists the following factors as helpful: 1. True psychotic reactions; 2. a disturbance at every level of adaptive function; 3. a fundamental pattern of withdrawal from reality; 4. a reliable history of some difficulties in adaptation to persons and to changes

in the immediate environment in the earlier years before the psychosis was apparent.

Abnormal electroencephalic tracings[3,17,20] have been described but they are in no sense characteristic. In one case (No. IV) herein reported, the tracings were "probably normal". Psychological tests[21,22] are unquestionably of value in supplying data which permit more accurate differentiation from other types of maladjusted children. That is well borne out in this series of cases.

In this series of cases, one child is also undoubtedly feeble-minded as well as schizophrenic. In this age-group, just as it is true among adults, schizophrenia may be present in an individual suffering from some organic brain disorder. This, however, does not warrant the assumption that the schizophrenia is of organic origin, although such an organic disorder may complicate it or contribute to the symptomatology shown.

PROGNOSIS AND TREATMENT

The prognosis in this series of cases does not appear to be too favorable. Recent reports, however, indicate that up to 50 per cent of schizophrenic children may show improvement.[17,18]

Treatment is primarily aimed at helping these children improve their personal and social relationships. Such attempts do tend to influence favorably the secondary symptoms but, of course, do not deal with the primary factors in the disease. Shock treatments[17,19] may be of benefit, although none of those here reported has had such treatment.

Psychotherapy should be undertaken both for the therapeutic value of the relationship and as an aid in socialization. At least some of these children are capable of making an attachment, usually dependent in type, that permits the child to work through his feelings of guilt and thus to become less anxious and fearful. Melanie Klein[23,24] has reported successful results from psychoanalytic therapy.

In view of the difficulty parents have in understanding and dealing with these children, parental guidance is imperative. This usually is a difficult job because of the nature of the parents themselves. However, many of these children will remain in or be returned to the family.

Certain drugs such as antuitrin-S and amphetamine[3,25] may temporarily favorably modify the behavior and thus help the child to gain confidence.

It is my firm conviction that treatment of these children can best be carried out in a hospital-school-institutional setting. Here the entire staff personnel can deal with the child according to his needs and his ability to respond and profit. Many types of art, drama, play and group therapies can be carried on in such a setting. Physical factors, if present, can be given adequate care. In fact only in such a setting can an all-round total approach be carried through.

BIBLIOGRAPHY

1. Lutz, J.: Ueber die Schizophrenie in Kindesalter. Schweiz. Arch. f Neurol. u Psychiat., 39:335, 1937, 40:141, 1937.
2. Lay, R. A. Q.: Schizophrenia-like Psychoses in Young Children. J. Ment. Sc., 84:105, Jan., 1938.
3. Bradley, Charles: Schizophrenia in Childhood. New York, Macmillan, 1941.
4. Bender, Lauretta: Childhood Schizophrenia. Nerv. Child, 1:138, 1942.
5. Bradley, C., and Bowen, M.: Behavior Characteristics of Schizophrenic Children. Psychiat. Quart., 15, 296, April, 1941.
6. Bradley, C.: Modern Trends in Child Psychiatry. Lewis and Pacella, Eds.; New York, International University Press, 1945.
7. Bleuler, E.: Textbook of Psychiatry. Authorized English Edition by A. A. Brill; New York, Macmillan Company, 1934.
8. Grunthal, Max: Ueber Schizophrenie in Kindesalter. Ztschr. f Psychiat., 46:206, 1919.
9. Potter, H. W.: Schizophrenia in Chidren. Am. J. Psychiat., 12:1253, May, 1933.
10. Grebelskaja-Albatz, E.: Zur Klinik der Schizophrenie des fruehen Kindesalter. Schweiz. Arch. f Neurol. u Psychat., 34:244, 1934; 3:30, 1935.
11. Despert, J. Louise: Schizophrenia in Children. Psychiat. Quart. 12:366, April, 1938.
12. Lurie, Louis A.: Quoted by Bradley, C. in Schizophrenia in Childhood, p. 24. New York, Macmillan, 1941.
13. Despert, J. Louise: Prophylactic Aspects of Schizophrenia in Childhood. Nerv. Child, 1:199, 1942.
14. Trainer, M.: Tagebuch ueber ein Geisteskrankes Kind. Ztschr. f kinderpsychiat., 1:91, Aug., 1941; 1:123-Oct., 1934; 1:154, Dec., 1934; 1:187, Feb., 1935; 2:17, Apr., 1935; 2:86, Aug., 1935; 2:115, Oct., 1935. See also a translation, Diary of a Psychotic Child, Bruch, Hilda, and Cottington, Frances. Nerv. Child 1:232, 1942.
15. Bradley, C.: Biography of a Schizophrenic Child. Nerv. Child. 1:141, 1942.
16. Kanner, L.: Autistic Disturbance of Affective Contact. Nerv. Child, 2:217, 1943.
17. Lourie, R. S., Pacella, B. L., Pictrowski, A. Z.: Studies on the Prognosis in Schizophrenic-like Psychoses in Children. Am. J. Psychiat., 99:542, 1943.
18. Cottington, Frances: Treatment of Schizophrenia of Childhood. Nerv. Child, 1:172, 1942.
19. Cottington, Frances: Treatment of Childhood Schizophrenia by Metrazol Shock Modified by B-erythroidin. Am. J. Psychiat., 98:397, 1941.
20. Clardy, E. R., Goldensohn, L. N., and Levine, K.: Schizophrenic-like Reactions in Children, Studies by Electroencephalography, Pneumo-encephalography, and Psychological Tests. Psychiat. Quart., 15:100, 1941.
21. Piotrowski, A. Z.: The Test Behavior of Schizophrenic Children. Proc. Am. A. Ment. Deficiency, 38:332, 1933.
22. Piotrowski, A. Z.: A Comparison of Congenitally Defective Children with Schizophrenic Children in Regard to Personality Structure and Intelligence Type. Proc. Am. A. Ment. Deficiency, 61:78, 1937.
23. Klein, Melanie: The Importance of Symbol-Formation in the Development of the Ego. Internat. J. Psychoanalysis, 11:24, 1930.
24. Klein, Melanie: The Psychoanalysis of Children. London, The Hogarth Press, 1932.
25. Bradley, C., and Brown, M.: Amphetamine (benzedrine) Therapy of Children's Behavior Disorders. Am. J. Orthopsychiat., 11:92, Jan., 1941.

Tuberculosis Calls

To diagnose the greatest possible percentage of unsuspected cases of tuberculosis, to place these people under immediate and adequate care, to render them and the community safe from further spread of their disease, to rehabilitate every patient into a productive member of society—these are our tasks. Diagnostic procedures that guarantee the maximum return in case finding are those that safely apply the clinical lessons of the past to the pressing problems of the present. No thorough clinician relies exclusively upon a solitary diagnostic aid, even when circumstances strongly tempt him to do so.—Ed., Tuberculosis Abstracts, National Tuberculosis Assn.

Use of Thiouracil in the Treatment of Hyperthyroidism

J. HAROLD KOTTE, M. D.

INTEREST in the non-surgical treatment of hyperthyroidism has recently been reawakened by the detailed study of various drugs capable of suppressing the activity of the thyroid gland. In 1941, the Mackenzies and McCollum[1] reported that sulfaguanidine produced thyroid hyperplasia in experimental animals. Shortly thereafter, similar goitrogenous changes were noted from thiourea by Richter and Clisby[2] and by Kennedy.[3] By 1943, these observations had been extended by the Mackenzies[4] and by Astwood and his associates,[5] who showed that the sulfonamides and thiourea produced not only thyroid hyperplasia but also suppression of the basal metabolic rate and independently concluded that the drugs interfered with the synthesis of thyroxin. Subsequently Astwood[6] investigated a large number of related compounds in animals and found 2-thiouracil to be one of the most active and least toxic of the drugs exhibiting this effect.

Astwood,[7] in 1943, was the first to report favorable clinical and metabolic response from thiouracil in patients with hyperthyroidism, although one patient treated with large doses developed agranulocytosis. Shortly thereafter, Williams and Bissell[8] confirmed the therapeutic value of thiouracil in the treatment of thyrotoxicosis.

The preliminary clinical reports stimulated more extensive studies of the use of thiouracil in the treatment of hyperthyroidism either alone, or as a preparation for surgery. There has been general agreement that the drug almost always lowers the metabolic rate and diminishes the symptoms and signs of thyrotoxicosis, whether due to diffuse hyperplasia or toxic adenoma. Thus far, the incidence of treatment failures has been placed somewhere between 2 per cent and 4.3 per cent, but even these figures may prove high in the light of further experience. When the drug is used alone, it has effectively controlled thyrotoxic manifestations and induced remission for the duration of the treatment period. When thiouracil is used preoperatively, thyroidectomy, even for severe hyperthyroidism, has been followed by fewer toxic reactions. Unlike other goitrogenous drugs, the action of thiouracil is not inhibited by iodine, although previous or concomitant administration of iodine usually delays the response to thiouracil.

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PHARMACOLOGY

The chemical grouping of thiouracil, -NH.CS.NH, has been shown[6] to be the biologically active constituent of this and other related drugs which inhibit thyroid function. While thiouracil is only slightly soluble in water, studies have shown that it is quickly absorbed from the gastro-intestinal tract and readily excreted in the urine. After absorption, thiouracil becomes widely distributed throughout the body fluids and tissues. The bone marrow and thyroid and pituitary glands have been found to contain more of the drug than other tissues.

Williams has shown that about 15 per cent of the amount ingested is destroyed in the gastro-intestinal tract, about 35 per cent excreted in the urine, and approximately 50 per cent destroyed by the body tissues.

The blood concentration of the drug is not necessarily stable on a fixed dosage, although frequent small doses have been found to maintain a better level than an equivalent, less frequently administered dose. Clinical experience has shown that 200 mg., three times daily, is a satisfactory and relatively safe dose with which to begin treatment. Determination of blood levels is unnecessary.

The mode of action of thiouracil has been the subject of considerable study. Experiments in animals have shown that the metabolic rate falls, growth is retarded, and signs of hypothyroidism may appear after its administration. Clinical experiments have shown that thiouracil prevents the usual rapid uptake of iodine by the thyroid gland and that the glands of treated

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Since this report was compiled, eight additional cases have been treated with thiouracil. To date, all have responded satisfactorily, although the BMR of one severe, iodine-resistant case reached normal only after three months' treatment. No toxic reactions occurred in this group.

Two cases of the group under treatment, reported above, relapsed shortly after the drug was discontinued. After medication was resumed, one of these exhibited a modrate neutropenia which necessitated withdrawal of the drug. Three patients have continued in remission for seven, nine, and twelve months; the fourth patient can not be located.

subjects contain less iodine and have less metabolic stimulating activity than normal glands or glands from patients with Graves' disease. These results, together with the improvement noted in thyrotoxic patients after its administration, indicate that the production of thyroxin is decreased by thiouracil, probably due to blocking of its synthesis from iodine and thyroglobulin. The resulting hyperplasia presumably results from uninhibited activity of the thyrotropic hormone of the pituitary, since hypophysectomy and thyroxin feeding prevent it in animals.

Thiouracil has also been shown to cause increased basophilia with decreased eosinophilia in the pituitary gland and a diminution in size of the adrenal glands. These changes are reversible and have not been associated with any known physiological disturbance. The offspring of thiouracil-treated animals exhibit retardation of growth and have hyperplastic thyroids. A few pregnant women with hyperthyroidism have been treated with thiouracil, but no deleterious metabolic effects on the child have been reported.

CLINICAL STUDY

We began to use thiouracil in the treatment of hyperthyroidism in 1943 and to date have administered it to 26 patients for periods varying from 3 weeks to 20 months. These patients were observed closely either in the hospital or clinic for at least 2 weeks before treatment was begun and during this control period pertinent clinical observations and laboratory tests, including a minimum of 3 basal metabolic rates, were done. Most of the patients were hospitalized during the first part of the treatment period. In all patients, observations were made of symptoms, weight, pulse rate, eye signs, size and consistency of the thyroid, basal metabolic rate, and blood and urine findings, weekly or oftener. The initial dosage of thiouracil was 0.6 gm. daily and the dose was later decreased to 0.4 gm., and finally to 0.2 gm., depending upon the degree of improvement. The basal metabolic rate has been the principal determining factor in deciding change in dosage. All patients were encouraged to take a high caloric diet and some were given vitamin supplements before or during treatment with thiouracil. Small doses of sedatives were also administered to a few of the more severely ill subjects. All of the hospitalized cases were given routine ward nursing care; many were placed in semi-private rooms but moved to the open ward when improvement occured.

RESULTS

Twenty-five of the 26 patients tolerated the drug sufficiently for study of its effectiveness. Analysis of the results will be presented under the appropriate headings.

Symptomatic Effects: All patients experienced relief from nervousness, restlessness and weakness to a degree comparable with the fall in the metabolic rate. Emotional lability was still increased in 3 subjects whose metabolism was normal or subnormal, although environmental factors may have been responsible for its continuance.

Weight Gain: All patients gained weight readily. The weight gain curve lagged only slightly behind the fall in metabolic rate. Weight gains ranged from 12 to 45 pounds, varying with the initial degree of malnutrition.

Eye Signs: Although measurements of the degree of exophthalmos were not made in all patients, no apparent change in this finding occurred during or after the treatment period. Others have occasionally noted a slight increase in exophthalmos, although at the same time describing relief in lid spasm. Desiccated thyroid has been reported to produce remission in thiouracil-induced exophthalmos in some cases.

Size and Consistency of the Gland: Thiouracil characteristically produces hypertrophy and hyperplasia of the thyroid gland, which microscopically shows increased cellularity, infolding of papillary processes into the acini, and areas of lymphoid hyperplasia. It should not be surprising, therefore, to find enlargement of the goiter after therapeutic use of thiouracil.

Six of 18 patients with diffuse goiter demonstrated moderate to marked enlargement of the gland after use of thiouracil for 3 to 7 months. In 3 cases the enlargement was sufficient to require operation for relief of pressure symptoms; in 2 additional cases slight increase in size was noted. No detectable enlargement in cases of nodular goiter was found.

The gland remained soft and the signs of increased vascularity did not disappear as evidences of hyperthyroidism subsided. This experience coincides with that of others. Use of iodine preoperatively in four patients led to increased firmness of the gland.

Hyperkinesis and Tremor subsided quickly in all patients exhibiting a favorable response to the drug. These gratifying changes were often the first noted by the patient and examiner.

Tachycardia and Other Circulatory Manifestations of hyperthyroidism responded favorably. Sinus tachycardia subsided in all patients as the metabolic rate fell. The pulse pressure decreased correspondingly and the circulation time (decholin) returned to normal in those cases where serial determinations were made. The apical rates of 4 patients with auricular fibrillation, which were poorly controlled with digitalis, decreased after use of thiouracil; in 1 patient auricular fibrillation reverted to normal rhythm. Although digitalis was also used in 4 cases with moderately advanced congestive failure, there was a tendency toward greater improvement after the

effects of thiouracil were apparent. Cardiac failure did not recur, even though 2 of these patients were carried for 11 and 18 months without digitalis but with thiouracil.

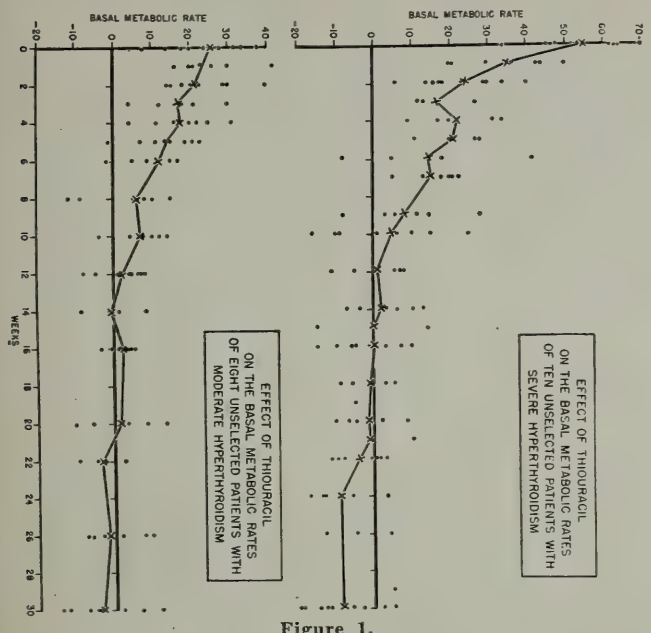


Figure 1.

Basal Metabolic Rate: The basal metabolic rate fell within normal range in 24 of 25 treated patients from thiouracil alone. The time required ranged from 2 to 12 weeks; in general, longer intervals were necessary for the more severely thyrotoxic patients. The average period for the severer cases was 6-7 weeks, for the milder cases 5 weeks. The patients who relapsed after thiouracil was discontinued responded just as favorably when the drug was re-administered.

Although the numbers and severity of the cases are not comparable, the basal metabolic rate of patients with nodular goiter appeared to decrease somewhat more slowly than patients with diffuse goiter.

The metabolic rate remained within normal limits in all 23 patients who continued to take the drug for longer than 6 months. The metabolic rate of 1 patient failed to return to normal after 5 months treatment with thiouracil. This patient, who had a moderately toxic nodular goiter, experienced a good result from subtotal thyroidectomy.

CASE REPORT

In order to illustrate the effects of thiouracil in hyperthyroidism, the following case is reported:

R. B., a 33-year-old colored male, a professional gambler, was first seen in the medical clinic of the Cincinnati General Hospital, in September, 1944, complaining of nervousness, excessive sweating, and weight loss of 2 months' duration. In addition, he had developed extreme fatigue, weakness, and a tremor of the hands which interfered with his customary dexterity. Heat intolerance, dyspnea, and palpitation occurred in the last few weeks. He was admitted to the hospital on November 8, 1944.

Examination disclosed a restless, agitated, and emotional male who had apparently lost weight recently. The skin was smooth, hot, and moist. Moderate exophthalmos, lid-lag, and stare were noted. The thyroid gland was diffusely enlarged and soft with signs of increased vascularity. The heart was not enlarged; tachycardia and a widened pulse pressure were noted. Muscular tremors and hyperreflexia completed the physical findings.

The diagnosis of Graves' disease was substantiated by B.M.R.s. of plus 56, plus 59, and plus 62, and by blood cholesterol ranging from 150 to 160 mgs. per 100 cc. After an observation period of 2 weeks during which all symptoms continued despite sedation, thiouracil, .6 gm. per day, was started. After 2 weeks, he noted improvement in restlessness and could sleep better. Weakness and fatigue diminished and he asked to be allowed to walk about. Following this he had an exacerbation of all symptoms and the B.M.R. rose to plus 42. The dose of thiouracil, which had been reduced to 0.4 gm. was increased to 0.6 gm. and finally to 0.8 gm., per day, after which improvement again occurred. The stare was noted to be lessened, tremors were diminished, and he began to gain weight. At this point, the thyroid gland was found to be somewhat larger and the bruit over it, louder. Exophthalmos was unchanged. The blood cholesterol was now around 240 mg. per 100 cc. and the B.M.R. plus 6. Because of general improvement he was allowed to leave the hospital after 11 weeks' treatment with thiouracil. At the time of discharge, slight nervousness, a labile pulse, and intention tremor were still present.

Thereafter, the patient was followed in the clinic. Slight nervousness and tremor persisted for a few weeks and then disappeared. He gained weight steadily and the tachycardia finally subsided. Meanwhile, despite medication with iodine for 1 month, the goiter increased in size. After 8 months' treatment, the thyroid was almost twice its original size, firm, and with slight thrill and bruit. All symptoms and signs of hyperthyroidism had disappeared.

Because of tightness in the neck and trouble with swallowing and talking a subtotal thyroidectomy was performed. The postoperative course was uneventful. The specimen removed weighed 300 gms. and was diffusely enlarged. Microscopic examination showed large acini lined with low cuboidal epithelium, and filled with pale-staining colloid. A few papillomatous projections from the wall of the acini were seen, as well as mild lymphocytic infiltration. The picture is that of an involuting thyroid.

This case serves to illustrate the regression of severe hyperthyroidism from thiouracil alone. No complications from treatment were noted except an increase in size of the thyroid gland which finally required thyroidectomy. This was not prevented by iodine. The microscopic picture of the gland is not typical of thiouracil effect and suggests that this patient would probably have had a medical cure if surgery had not been required for the large goiter.

TOXICITY

Toxic reactions to thiouracil have constituted the greatest disadvantage to its widespread use

and were the principal reason for its delayed release to the profession at large. Thus far, adverse reactions have been reported to occur in 12 per cent to 15 per cent of all who took thiouracil. Among the reactions noted have been leukopenia and granulocytopenia, fever, skin rashes of various types, toxic psychosis, jaundice, edema, arthritis, purpura, hematuria, nausea, vomiting, diarrhea, and enlargement of the salivary glands.

Agranulocytosis is the most dreaded of these complications of treatment and has been the subject of numerous detailed reports. Recent surveys covering 1,091[9] and 5,745[10] patients treated with thiouracil have disclosed an incidence of granulocytopenia of 1.7 per cent and 2.5 per cent, respectively, and a total mortality rate from this disorder alone of about 0.5 per cent. Leukopenia, arbitrarily defined as a fall in the total white blood count to 4,000 or below, occurred in roughly 4 per cent of all thiouracil-treated patients. However, thyrotoxicosis itself may lead to decrease in the total white count and relative decrease in the granulocytic series, so that serial determinations during treatment are necessary. Granulocytopenia has occurred mainly within the first 8 weeks of treatment, the highest percentage developing in the first 4 weeks. The daily dosage of the drug has not appeared important, although duration of use and previous administration of thiouracil have been correlated with depression of the granulocyte series.

One case of granulocytopenia occurred in this series of 26 patients. This case developed in a 37-year-old white female with diffuse enlargement of the thyroid and hyperthyroidism, 23 days after the first administration of thiouracil (0.6 gm. day). At this point swollen and tender gums, sore throat, and generalized aching were noted and followed shortly by fever (101°) and discrete ulceration of the gums and pharynx. She recovered uneventfully after receiving penicillin, thiamin, pyridoxine, and pentnucleotide. The rapid onset of agranulocytosis, as demonstrated here, requires close observation of all patients who take the drug.

Fever has also been a common early toxic symptom, occurring in 3.5 per cent of 457 cases collected from the literature by McArthur and her coworkers. Like the leukopenic reactions just described, it is considered an idiosycratic reaction to the drug. Fever developed once in our series, subsided after discontinuing thiouracil, and recurred again with a chill following a single dose of 0.2 gm.; however, it did not reappear after restarting later with 0.1 gm. thiouracil which was increased slowly over an 8-week period to a daily dose of 0.6 gm.

Two cases of diffuse maculopapular rash have been observed in this series. One patient with generalized edema and another patient with ankle edema have also been noted; in both instances the edema disappeared when the drug was stopped. In neither case was the edema correlated with heart failure or low serum protein.

Because of toxic reactions to thiouracil, derivatives with the same active chemical linkage have been investigated in the hope of finding one devoid of such properties. Thiobarbital has been used successfully where idiosyncrasy to thiouracil exists, but was found more toxic when the minimal effective dose was exceeded. More recently, 6-ethylthiouracil and 6-n-propylthiouracil have been shown to be about 5 times as active as thiouracil in man and considerably less toxic when given in a comparably effective dose. We have used para-aminobenzoic acid in 3 patients and have not been able to confirm the report of its efficacy in hyperthyroidism.

RESULTS OF TREATMENT

The following are the results from use of thiouracil in this series of 26 patients, Of the 24 patients responding satisfactorily, 15 were treated with thiouracil alone. Ten of these 15 patients improved and have remained in remission from 4 to 20 months while taking daily maintenance doses (0.1 to 0.2 gm.) of the drug. No definite relapses have been observed while thiouracil was given, although increase in dosage was occasionally necessary in a few cases where relapse under maintenance treatment seemed imminent. However, 5 patients relapsed within 14 weeks after stopping thiouracil. On the other hand, 4 patients have gone from 2 to 7 months without the drug.

The natural history of hyperthyroidism is often marked with spontaneous remissions and recurrences, so that prolonged observation will be required before the true significance of these remissions become apparent. Since 66 per cent of recurrences developed within the first month after stopping thiouracil in Williams' series, the duration of remission becomes significant.

Six of the 9 cases treated with thiouracil and later operated were given this drug as preoperative preparation instead of iodine. Subtotal thyroidectomy was deemed necessary because of initially large glands, nodular goiters, idiosyncratic reactions to the drug, or the desire of the patient for surgery. All patients withstood the operation without reactions; bleeding and friability of the glands were largely controlled by preoperative use of iodine.

An unexpected need for surgery was presented by 3 patients whose goiters enlarged greatly after taking thiouracil. Others have noted similar changes in size of the thyroid although, in general, the reports have described little or no effect on gland size. Both iodine and thyroxin have been recommended to control growth of the goiter. Use of iodine in these 3 cases during thiouracil administration and preoperatively

produced increased firmness but no detectable decrease in size of the gland.

Treatment was discontinued in 2 cases because of unfavorable results. One case developed granulocytopenia; in 1 patient the drug failed to induce remissions of the hyperthyroidism.

DISCUSSION

At this point one should attempt to evaluate the status of thiouracil in the treatment of hyperthyroidism. From this and from other reports it is evident that thiouracil and related drugs can control thyrotoxicosis in the vast majority of cases. The questions which need answers are: Is thiouracil superior to iodine in the control of hyperthyroidism or as preoperative medication? Can thiouracil take the place of surgery? Do the toxic reactions outweigh the clinical usefulness of this drug? Unequivocal answers to all these problems are not yet justified.

While iodine is relatively non-toxic and of proven value in the control of hyperthyroidism it is also true that it is occasionally ineffectual in severe hyperthyroidism and that its action is usually temporary, requiring that surgery be done within certain time limits. Postoperative thyrotoxic reactions occur often enough, despite iodine, to be troublesome. Thiouracil, while it acts more slowly, also acts more certainly, appears to lessen thyroid crises after surgery, and exerts its metabolic depressing effect as long as the drug is administered, permitting the surgeon to delay thyroidectomy until the patient is better prepared for it. The technical difficulties imposed on the surgeon by a thiouracil-treated gland have largely been overcome by the additional use of iodine preoperatively. In these respects, thiouracil would seem to have the advantage.

It is still premature to state that thiouracil can or will ever take the place of surgery in the treatment of hyperthyroidism. Neither treatment is considered to attack the basic cause of this disorder, the etiology of which remains unknown. While the relapse rate after subtotal thyroidectomy is not accurately known, it is certainly not near the 50 per cent recurrence rate found thus far after stopping thiouracil. Surgery is still preferred for patients with very large or adenomatous glands, or for those who will not or can not remain under the close observation that thiouracil demands. On the other hand, thiouracil seems better for patients with postoperative recurrence, for certain thyrocardiacs who discourage even the bravest surgeon, and for the occasional patient who refuses surgery at any cost. Further observation will probably dictate more precise criteria for selection of treatment.

The toxicity of thiouracil has not yet proved a deterrent to its use. However, thus far the reports have come from clinics where close observation could forestall serious trouble from granulocytopenia. One can not say what the results will be from injudicious use by an unwary or over-busy practitioner. We have already seen cases of unsuspected neutropenia from thiouracil administered in clinic practice. The physician who uses this drug obligates himself to follow the patient carefully throughout the treatment period, especially with regard to white and differential blood counts. Perhaps these hazards will soon be overcome by use of a less toxic derivative.

At present, it has been our practice to check the the total white blood count 2 or 3 times weekly during the first 2 months of treatment, and weekly thereafter. In ambulatory patients differential counts are done only when a significant decrease in white cells is found. Patients are warned of the symptoms of agranulocytosis-chills, fever, aching, sore throat or gums, and unusual malaise, and are told to report their occurrence at once.

TABLE I

Summary of Results From Use of Thiouracil in the Treatment of Hyperthyroidism

TOTAL NUMBER OF CASES TREATED (3 weeks to 20 months)	26
NUMBER OF CASES RESPONDING SATISFACTORILY	24
A. Cases treated with thiouracil alone	15
Cases in remission under maintenance treatment	10
Cases relapsing after discontinuing thiouracil	5
Cases still in remission after discontinuing thiouracil for 2 to 7 months	4
B. Cases treated with thiouracil and subsequently operated	9
Cases taking thiouracil as preoperative preparation	6
Cases operated because of thiouracil-induced goiter	3
NUMBER OF CASES RESPONDING UNSATISFACTORILY	2
Treatment discontinued because of toxic recation (granulocytopenia)	1
Treatment failed to induce remission	1

CONCLUSIONS

1. Thiouracil relieves the symptoms and lowers the metabolic rate in hyperthyroidism, as indicated by its effect in 24 of 25 patients in this series.

2. The average time required for return of the metabolic rate to normal limits was 5 to 7 weeks, varying somewhat with the degree of elevation before treatment.

3. Improvement in the manifestations of hyperthyroidism has continued as long as treatment was maintained.

4. The recurrence rate of hyperthyroidism after stopping thiouracil is high enough to cast doubt on the value of medical treatment solely with this drug. However, further observation will be needed to settle this point.

5. The frequency and suddeness of toxic re-

actions, especially granulocytopenia, makes it mandatory that every physician closely follow patients receiving thiouracil.

6. Thiouracil is especially valuable in patients with severe hyperthyroidism, patients with postoperative recurrence, patients who are "iodine-fast", patients with severe cardic complications of thyrotoxicosis, and those who refuse operation.

BIBLIOGRAPHY

1. MacKenzie, J. B., MacKenzie, C. G., and McCollum, E. V.: The Effect of Sulfonilylguanidine on the Thyroid of the Rat. Science, 94:518, 1941.

2. Richter, C. P., and Clisby, K. H.: Toxic Effects of the Bitter-Tasting Phenylthiocarbanide. Arch. Path., 33:46, 1942.

3. Kennedy, T. H.: Thioureas as Goitrogenic Substance. Nature, London, 150:233, 1942.

4. MacKenzie, C. G., and MacKenzie, J. R.: Effect of Sulfonamides and Thioureas on the Thyroid Gland and Basal Metabolism. Endocrinology, 32:185, 1943.

5. Astwood, E. B., Sullivan, J., Bissell, A., and Tyslowitz, R.: Action of Certain Sulfonamides and of Thiourea Upon the Function of the Thyroid Gland of the Rat. Ibed., 32:210, 1943.

6. Astwood, E. B.: The Chemical Nature of Compounds Which Inhibit the Function of the Thyroid Gland. J. Pharm. and Exp. Therap., 78:79, 1943.

7. Astwood, E. B.: Treatment of Hyperthyroidism with Thiourea and Thiouracil. J.A.M.A., 122:78, 1943.

8. Williams, R. H., and Bissell, G. W.: Thiouracil in the Treatment of Thyrotoxicosis. N. Eng. J. Med., 224:97, 1943.

9. A Cooperative Study Compiled by F. D. Moore, "Toxicity of Thiouracil". J.A.M.A., 130:315, 1946.

10. Van Winkle, W., Hardy, S. M., Hazel, G. R., Hines, D. C., Newcomer, H. S., Sharp, E. A., and Sisk, W. N.: Toxicity of Thiouracil. J.A.M.A., 130:343, 1945.

Clinical Significance of the Rh Factor

1. Rh testing should be performed routinely on all donors and recipients prior to the blood transfusions and only Rh negative blood used on Rh negative individuals, if one wishes to avoid intragroup transfusion reactions.

2. Sensitization of an Rh negative woman may occur from recently Rh positive blood by any route and may result in the delivery of an erythroblastotic infant.

3. Rh testing should be a part of the prenatal routine of all women, particularly those women who have a history of having a stillborn child or an erythroblastotic child.

4. It would be helpful if Rh negative women with Rh positive husbands had tests for antibodies during their pregnancy, particularly the latter months of the pregnancy, using the Diamond slide test or the Wiener conglutination test.

5. Stillbirths should be autopsied for evidence of erythroblastosis.

6. All babies of Rh negative mothers and Rh positive fathers should be closely observed during the first few days of life for signs of erythroblastosis, and prompt therapy instituted, if they occur.—Henry C. Allen, M.D., St. Louis, The Jr. of the Mo. State Med. Assn., Vol. 43, No. 11, November, 1946.

KEEPING UP WITH MEDICINE

WE pride ourselves that in recent years man has been winning his fight against one of the most successful creatures of all time—the plasmodium of malaria. We forget that malaria disappeared for 400 years from Rome only to come back stronger than ever. Let's not be too sure.

* * *

IN diabetes the parents of the child must not become over protective and spoil their child's social adjustments. At the same time, they should be taught the nature of the illness and what their role as parents should be.

* * *

GRAMICIDIN (tyrothricin) is effective against some aerobic and anaerobic pneumococci, streptococci, and certain staphylococci and can be used as nose drops, spray, or displacement as nasal medication in sinusitis.

* * *

PENCILLIN diminishes the severity of upper respiratory infection more effectively than sulfadiazine.

* * *

THE experts are now saying that whole blood is to be used in preference to plasma because it furnishes more for the patient.

* * *

CHRONIC vitamin C deficiency alone or in combinations with other deficiencies such as iron or erythrocyte maturing factor has been reported as the cause of an anemia which will not respond optimally until adequate ascorbic acid therapy is instituted.

* * *

SUCH diseases as chronic pyelonephritis, tumors of the pituitary or adrenal glands, coactation of the aorta, and brain tumors—all must be ruled out before a diagnosis of essential hypertension can be established. Essential hypertension constitutes the largest group of all, and, as a cause of death, is several times more common than cancer.

* * *

UP to 1944, 404 outbreaks of botulism were reported with 1,125 cases and 732 deaths, a mortality of 62 per cent.

* * *

RABIES was well described by Aristole about 400 B. C. Celsus in the first century of the Christian era recorded human cases.—J.F.

The Use of Vitamin C in Traumatic Shock

HARRY N. HOLMES, Ph. D.

TRAUMATIC shock, whatever the causes, is accompanied by a decrease in blood volume and pressure. Increased capillary permeability, accepted by many as a most important feature of shock, results in loss of blood plasma into surrounding tissues. Increased concentration of the red blood cells following loss of plasma is readily measured by hematocrit readings.

Transfusions of whole blood or plasma, or even of solutions of pectin, gelatin, or glucose and saline restore the pressure and volume of blood.

As a supplement to such well-known therapy, in fact as an occasional emergency substitute, this paper offers clinical evidence of the value of vitamin C given orally or intravenously.

INTRAVENOUS INJECTIONS OF VITAMIN C

As reported in Science,[1] a group of surgeons in a Western city were highly successful in treating patients collapsing after operations, by intravenous injections of 500 mg. or even 1000 mg. of vitamin C (in sterile, partly buffered solutions). It is generally accepted that a very low level of ascorbic acid is one of the causes of increased permeability of the capillary wall with consequent loss of plasma. Excess of this vitamin makes for a healthy, normal condition of the capillaries, possibly by acting as a detoxifying agent, or possibly by combating tissue anoxia. In a recent war year, 1943, an amazing number of ampules of vitamin C solution were prepared for some countries, as yet not disclosed. Presumably valuable clinical information was obtained.

At my suggestion, Dr. Harold G. Kuehner of Mercy Hospital, Pittsburgh, kindly consented to extend these earlier experiments. His report in April, 1945, follows, with the caution that comparisons are difficult. "However, I can tell you that during the past six months I have given massive doses up to 2000 mg. of vitamin C intravenously, both pre-and postoperatively to 50 seriously ill patients who underwent major abdominal operations. These were gastric resections, seriously complicated gallbladder and liver operations, rectal resections, and bowel resections, not simply run-of-mine laparotomies.

"I am definitely convinced that these cases have made a more prompt and more vital convalescence with less serious complications or sequellae than 50 such cases which were operated on without the aid of vitamin C."

Submitted April 16, 1946.

The Author

● Dr. Holmes, Oberlin, Ohio; B.S., Westminster College, Pa., in 1899; Ph.D., Johns Hopkins University, 1907; President, American Chemical Society, 1942; retired head, Department of Chemistry, Oberlin College.

ORAL ADMINISTRATION OF ASCORBIC ACID

In battle, auto accidents, or accidents in home or factory, there may be a dangerous delay in receiving adequate medical aid. Consequently it was evident that oral administration of vitamin C tablets—requiring no technical skill—should be tested for influence in lessening secondary shock in spite of a belief that some vitamins are more effective when given by injection. The minor surgery of tooth extraction afforded convenient opportunities for the test.

VITAMIN C IN DENTAL SURGERY

Dr. Charles Wilbur Carrick of Oberlin, Ohio, was the first dentist to cooperate (in 1942) and he has continued ever since with great enthusiasm. He was advised to give the adult patient 500 mg. of vitamin C, by mouth, from 30 to 45 minutes before tooth extraction. Admittedly, only a lesser fraction of such patients without aid of ascorbic acid would complain of shock or postoperative weakness, yet, in many cases, shock is quite severe. Over 30 years ago, Dr. Martin H. Fischer insisted that tooth extraction was not a trifling affair, but required more or less postoperative rest.

Several other dentists cooperated with generally excellent results. Since little or no postoperative weakness was reported, out of perhaps 2,000 cases, it seemed fair to credit some value to the oral use of vitamin C. A few brief statements from cooperative dentists follow:

Dr. George M. Quinn of Chicago reporting for the five dentists of his group wrote: "We used 900 mg. of vitamin C giving it by mouth in doses of 100 mg. each, three times daily for three days before the extractions. With this, we used 7.5 grains of sulfadiazene every four hours for three days. After the extraction we used the same dosages as before. Sulfadiazene was increased

to 15 grains every four hours and then reduced to 7.5 grains every four hours for the next two days.

"Shock was almost completely eliminated, as well as severe postoperative pain. In none of the cases did we have muscle trismas."

Dr. Quinn added the sulfa treatment on his own initiative. It should be stated that he receives a large number of very difficult extraction cases sent by other dentists.

Dr. Harold L. Aylesworth, Cleveland Heights, Ohio, reported: "We have had a chance to administer vitamin C, as recommended by you, in severe surgical cases to the same patients in whom we had previously observed shock. The lack of shock in case after case was so evident that I can enthusiastically say that large doses of vitamin C certainly do seem beneficial in the alleviation of shock."

Dr. B. E. Saunders, Elyria, Ohio, wrote, "There was very marked freedom from shock in most of the cases (about 200) given 250 or 500 mg. of vitamin C. There were no dry sockets and these patients were more relaxed in the chair."

Dr. Paul J. Aufderheide, Cleveland, reported: "Twenty-seven patients that I had operated on before and proved neurotic, were given 250 mg. of vitamin C. These patients experienced less reaction in comparison to their previous experience."

As an illustration of an extreme case it may be added that a patient having a dead brittle molar extracted was in the chair two hours. The dentist urged him to go home to bed and to take codeine. However, the patient went at once to a gay social gathering and returned home after six hours "feeling fine".

These results in dentistry seemed to justify further tests in major surgery.

ORAL USE OF VITAMIN C IN MAJOR OPERATIONS

With a view to emergency use of vitamin C tablets by wounded soldiers, I asked Dr. Harold G. Kuehner, who has great numbers of coal mine accident cases to care for, to have his first-aid staff administer 500 mg. of vitamin C orally to the injured men at the mine in order to help them during the delay in transportation to Mercy Hospital, Pittsburgh. In July, 1945, he wrote as follows:

"We have used vitamin C tablets in approximately 35 assorted cases of miner's injuries to date. We have not used it on the very simple ones nor on those with some degree of early shock. This group includes three badly fractured pelves, a fractured humerus, a fractured femur, and two chest crushes. The remainder were lesser fractures, contusions, etc. Of course, the evaluation of results is extremely difficult because of the fact that the reports are all relative and personal, but I am thoroughly satisfied that there is betterment in these cases as compared with similar ones. When they reached the hospital we seem to be able to go ahead with vital procedures indicated more readily than when we were not using vitamin C."

Dr. George M. Curtis of Ohio State University Medical School kindly consented to make some preliminary tests of the value of vitamin C in preparing patients for major operations. He reported as follows: "We have made a number of preliminary tests with vitamin C tablets giving them preoperatively to patients who were to undergo severe surgical operations. These observations have been encouraging." Later, "We have continued to use vitamin C preoperatively. The clinical results are good. However, they should be more carefully controlled before being presented." On April 8, 1946, he wrote, "There is now little doubt of the value of vitamin C in the prevention of shock."

Dr. R. H. Aldrich, Boston, wrote in March, 1944, "I have been using vitamin C in the treatment of shock for over a year and am very well pleased with the results. Most of the cases in which it has been used have been severe burns but I have also used it on preoperative cases in an attempt to lessen surgical shock, with good results so far." Later he wrote, "Since 1944, I have been using vitamin C routinely to lessen traumatic shock and preoperatively to prevent or lessen surgical shock. The end results were uniformly good."

Dr. R. W. Bradshaw had a patient in the Oberlin College hospital with serious illness complicated by alarming bleeding into the urine. My suggestion that capillary weakness might be corrected by 500 mg. of vitamin C was adopted and the bleeding stopped early the next day.

Two cases of chronic bleeding of the gums and one of repeated nose bleeding (following prolonged sulfa drug treatment) were promptly relieved by large oral doses of vitamin C. Six more operations, most of them abdominal, were accompanied by administration of 500 mg. of vitamin C an hour before. Freedom from shock and speed of recovery were gratifying to the surgeons.

The value of excess vitamin C in wound healing is generally recognized but its relation to shock prevention has not yet found general favor. However, one or two references to the literature may be interesting.

McDevitt, Duryea, and Lowenstein[2] believe: "Vitamin C plays a definite role in the picture of traumatic shock."

Wolfer[3] states: "The deficient patient should receive 1,000 mg. of ascorbic acid daily for ten days before any surgical procedure is attempted and this should be continued until wound healing is complete."

Andrus and Barnes[4] agree and add: "For the poor sick patient not frankly deficient in vitamin C, smaller doses (200 mg.) may suffice."

TIME CONCENTRATION STUDIES

Miss Margene Anderson cooperated in an effort to learn the time required for peak concentration in blood plasma after oral administration of vitamin C. Data are taken from her publication[5] and from personal communications.

With 20 healthy people, after a few days on a fasting level, the vitamin C content of blood plasma fell to a few tenths of a milligram per 100 cc. All were then given 250 mg. of the vitamin by mouth for the first series. Maximum concentrations were observed in one or two hours. On repeating the experiment with higher intakes, the peak was generally reached in two or three hours.

Number of people reaching peak concentration in given time:

Dose	1 hr.	2 hrs.	3 hrs.	4 hrs.
250 mg.	7	10	3	0
500 mg.	1	9	10	0
750 mg.	3	8	8	1
1000 mg.	0	8	11	1

Apparently the tissues removed this vitamin from plasma quite rapidly and so only after saturation is a peak concentration attained in the plasma. Helpful effects in the tissues may occur sooner than the plasma reading indicates. After six hours, the blood plasma concentration of most of the people given only 250 mg. returned to the fasting level, but with those given 500 mg. or more, the plasma concentration after six hours ranged from 0.2 mg. to 0.7 mg. per 100 cc. higher than the fasting level. Concurrent twelve-hour urinary excretion showed that the larger the test dose of vitamin C (within the limits stated) the greater the amount retained in the body. There was not much gain on increasing the dose above 500 mg., but it was clear that 500 mg. was distinctly superior to 250 mg.

With intravenous injections a greater percentage of vitamin C administered was lost in the urine (in the first four hours) than when given orally, ranging from 25 to 65 per cent. The peak concentration in plasma after intravenous injections was reached in three to five minutes but the high plateau level was of distinctly shorter duration than in cases of oral administration.

In my own laboratory, one person's plasma level, after oral intake of this vitamin, rose in 45 minutes from 0.60 mg. per 100 cc. to a peak of 1.51 mg. An hour later it was 1.48 mg. With another person, plasma level rose in 75 minutes from 0.44 mg. to a peak of 1.10 mg.

DISCUSSION

If capillary loss of plasma is accepted as the primary feature of traumatic shock, the possibility of increase in capillary permeability by action of toxic products deserves careful consideration. There has been much controversy over this toxic theory yet there is no debate on the value of adequate amounts of vitamin C in helping maintain a healthy condition of the capillary wall.

It is possible that vitamin C acts as a detoxifying agent in shock treatment (whatever the toxins may be) as it has been shown to be in lead poisoning,[6] in the disturbances caused by organic arsenic and bismuth compounds, sulfa drugs,[7] and factory dusts. There may be some significance in my finding that histamine and vitamin C in the presence of oxygen, react with accelerated destruction of both.

Dale[8, 9] and associates blamed histamine in traumatic shock or products of protein cleavage due to bacteria in severe infections for the loss of tone and increased permeability of capillary endothelium.

Harkins and Harmon[10] report loss of plasma-like fluid from the blood stream in burns, freezing, pneumonia, bile peritonitis, acute pancreatitus, and other conditions. Barsum and Gaddum[11] observed a five-fold increase in the concentration of blood histamine during the first week after severe burns. Lewis[12] believed that the fluid lost from circulation on prolonged exposure to cold was caused by histamine-like substances released from injured cells and acting on the walls of blood vessels.

Slotkin and Fletcher[13] found that ascorbic acid, by decreasing capillary permeability, is of great value in the complication of "wet chests" that sometimes follows prostatic surgery in elderly, debilitated patients. It is a valuable adjunct, they stated, in tiding patients over the critical postoperative period irrespective of the blood levels or amounts of deficiency demonstrated to be present before or during the operation.

The effect of anoxia in shock is stressed by several workers. It would seem that the oxidation-reduction cycle of vitamin C may be of value in combating anoxia. Andrus[14] states: "There would seem to be fairly uniform agreement that oxygen utilization is diminished in shock." Krogh [15] and others emphasize the fact that anoxia by damaging capillary endothelium and thus increasing capillary permeability, is the second major factor in shock. Blalock[16] asks for additional information on the question: "Are vitamin C and thiamin, in the absence of defi-

ciencies, helpful in the prevention and treatment of shock?"

SUMMMARY

1. Vitamin C, 500 mg. for a patient of average weight, if given orally within the hour before operation, materially decreases traumatic shock as shown by much clinical evidence.

2. In the minor surgery of teeth extraction, oral administration of 500 mg. of vitamin C within the hour before operation is remarkably successful in preventing shock or postoperative weakness.

3. Immediate administration of 500 mg. or more of vitamin C to 35 assorted cases of accidents at coal mines seemed to increase shock resistance and to improve the condition of the patients upon arrival at a distant hospital.

4. Intravenous injections of 500 or 1,000 mg. of vitamin C in sterile, buffered solutions was used preoperatively and postoperatively in a series of 50 major abdominal operations with excellent results.

5. The peak concentration in blood serum of 20 healthy persons after oral intake of 500 to 1,000 mg. of vitamin C was generally observed in two or three hours, rarely in one hour. After six hours the level was still higher than the initial level.

6. With intravenous injections the plasma peak was reached in three to five minutes but the high plateau level was of shorter duration than with oral administration.

BIBLIOGRAPHY

1. Holmes, H. N.: Science, 96, 384, 1942.
2. McDevitt, G. S., Duryea, A. W., and Lowenstein, B. E.: Southern Med. Jr. 37, 208, 1944.
3. Wolfer, J. C.: S. Clin. North America, 20, 225, 1940.
4. Andrus, W. D., and Barnes, W. A.: S. Clin. North America, 25, 350, 1945.
5. Anderson, M.: Pro. Soc. Exptl. Biol. Med., 60, 12, 1945.
6. Holmes, H. N., Campbell, K., and Amberg, E. J.: J. Lab. Clin. Med., 24, 1119, 1939.
7. Holmes, H. N., Ohio State Med. J. 41, 923, 1945.
8. Dale, H. H., and associates: Jr. Physiol., 52, 110, 1918.
9. Dale H. H., and associates: Pro. Roy. Soc. Med., 28, 1493, 1935.
10. Harkins, H. N., and Harmon, P. H.: Ann. Surg., 106, 1070, 1941.
11. Barsum, G. S., and Gaddum, J. H.: Jr. Physiol., London, 85, 1, 1935.
12. Lewis, T.: Brit. Med. J., 3, 869, 1941.
13. Slotkin, G. E., and Fletcher, R. S.: Jour. Urol., 52, 566, 1944.
14. Andrus, W. D.: Int. Abst. Surgery, 75, 161, 1942.
15. Krogh, A.: The Anatomy and Physiology of Capillaries. Yale University Press, 1922.
16. Blalock, A.: Surgery, 14, 487, 1943.

Many different factors are involved in the pathogenesis of the renal insufficiency which occurs in so many different extrarenal disorders. A proper evaluation of these factors is of vital importance. Treatment of shock or congestive heart failure and correction of dehydration or salt depletion as the case may be can be expected to result in dramatic improvement in renal function in many cases.—Edw. H. Reinhard, M.D., St. Louis, The Jr. of the Mo. State Med. Assn., Vol. 43, No. 10, October, 1946.

Penicillin Facts and Rumors

Recent articles in periodicals of wide circulation have created unwarranted fears in the minds of the public concerning the value of penicillin and other new remedies.

Unfortunately, some of the articles are factually incorrect. The creation of doubts and fears in the minds of patients concerning the therapy which they receive may prevent the fullest realization of benefits from treatment.

Physicians should be in a position to give their patients the facts concerning penicillin and to allay any doubts or fears created by these publications. Briefly, the facts concerning the latest developments in penicillin therapy are as follows:

1. Commercial penicillin has consisted of varying mixtures of one or more of the five known fractions, F, G, X, K, and dihydro F.

2. Penicillin K is apparently rapidly destroyed or eliminated in the body, and therapeutic levels are not achieved or maintained in the body fluids following ordinary doses.

3. Commercial penicillin now available is predominantly penicillin G, which is known to be effective although some of the penicillin produced for a few months in 1945 may have had relatively less G and more K than previous or subsequent batches.

4. As far as facts are available, penicillins F and X are as active clinically as penicillin G. Further research will be necessary to define their usefulness with preciseness.

5. Since precise methods are not available for the routine determination of the quantities of each fraction in each batch of penicillin, the National Research Council has recommended increased dosage of penicillin as a safety precaution, particularly in the treatment of syphilis, in which the end result of therapy can not be evaluated for a long time.

6. Although bacteria have been made resistant to penicillin in the test tube, development of clinical resistance has not become a problem. Such an eventuality may be prevented, in part, by giving adequate and not minimum doses of penicillin.

7. All penicillin and penicillin pharmaceuticals currently on the market have been examined and certified as to safety and efficacy by the United States Food and Drug Administration.

8. It is possible that natural or synthetic variations of the penicillin molecule will result in the development of a clinically better penicillin. None better than pencillin G is now available.—Report of Council on Pharmacy and Chemistry, American Medical Association, August 24, 1946.

Tuberculosis in Mental Schools and Hospitals in Ohio

MARK W. GARRY, M.D.

THIS is a report of the extent of the tuberculosis problem in the mental schools and hospitals in Ohio. It reveals the existence of a reservoir of tuberculosis which constitutes a serious public health problem; it is a source of infection which has not received the attention it demands.

A tuberculosis case-finding survey, utilizing transportable 35 mm. photofluorographic equipment on loan from the U. S. Public Health Service, was conducted in the mental schools and hospitals in Ohio during the period from December 17, 1945, to May 6, 1946. All screening films and 14" x 17" X-ray retake films were read and recorded by the Division of Tuberculosis, Ohio Department of Health.

The Ohio Department of Public Welfare, which is responsible for the care of the patients of state institutions, has been interested for some time in determining the prevalence of tuberculosis in the mental schools and hospitals as the basis for the development of an adequate control program. There was early recognition of the potential hazards of institutional life to the physical welfare of both patients and employees and certain individual hospitals had initiated limited programs to remedy the defect. However, it was realized that only through the application of mass survey technique would it be possible to ascertain, within reasonable limits, the precise nature of the hazard and thereby provide the fundamental knowledge upon which to build this future program of tuberculosis control.

This study embraced the total population of twelve of the fourteen mental schools and hospitals in the state. One institution was not included because of lack of an adequate power source. Another failed to segregate the patients from the employees during the survey and so prevented a comparative analysis.

SURVEY PROCEDURE

Seven to ten days before starting a survey, the institution was visited and a site was chosen which was adaptable to the purpose and sufficiently close to required power source.

Mark sensing cards for the entire institutional population, patients and employees, were turned over to the superintendent with instructions to have the name, age, sex, and race of all patients entered in black type and of all employees entered in red type and the cards arranged in alphabetical order.

On the day that the photofluorographic unit arrived at the school or hospital, the cards were given to the chief technician who then arranged the schedule by wards and buildings.

The patients were brought to the unit under supervision of attendants and were positioned, without disrobing, in the best possible manner. It was realized from the beginning that uniformly good X-ray films would be difficult to obtain because of the nature of the patients' mental state. Because of refractory tendencies or physical deformities proper positioning was often an impossibility. In a number of cases, the patients could not cooperate by taking a deep breath and holding it during the exposure. In spite of these manifestly undesirable factors it was possible, through repeated exposures in some instances or the application of restraint in others, to achieve a high percentage of satisfactory films. Between 600 and 800 individuals were X-rayed daily, the films were screened by the Division of Tuberculosis, retakes were advised for suspected tuberculosis, suspected nontuberculous pathology, or unsatisfactory films, and these retakes were obtained on 14" x 17" celluloid film. The large films were then sent to the Division of Tuberculosis for interpretation and recommendations.

Statistical analyses, interpretations, and rec-

TABLE I

Population, Known Tuberculosis Cases, Number of Deaths in Institutions, Number and Per Cent of Total Deaths Due to Tuberculosis, Ohio Mental Hygiene Institutions, 1941-1945

Year	Population	Tuberculosis Cases Known	Total Deaths All Causes	Deaths Due to Tuberculosis	
				Number	Per Cent
1941	27,418		1,514	218	14.4
1942	27,589		1,544	202	13.1
1943	27,372	128	1,892	230	12.2
1944	27,793	148	1,831	218	11.9
1945	28,278	351	1,780	226	12.7

The Author

● Dr. Garry, Columbus, Ohio, is a graduate of Marquette University School of Medicine, Milwaukee, Wisconsin, 1934; diplomate, American Board of Internal Medicine; associate, American College of Physicians; member, American Trudeau Society; formerly, Chief, Division of Tuberculosis, Ohio Department of Health; and now, Chief, Tuberculosis and Internal Medicine, Div. of Mental Hygiene, Dept. of Public Welfare.

Submitted July 26, 1946.

TABLE II

General Information—Mental Surveys 2 to 13 Inclusive

	Number	Per Cent
Total Population	32,572	100.0% of Total Population
Patients	29,203	89.6% of Total Population
Employees	3,369	10.4% of Total Population
Total Screened	25,351	77.8% of Total Population
Patients	22,387	76.7% of Total Patients
Employees	2,964	88.0% of Total Employees
Total Retakes	2,393	9.4% of Total Screened
Patients	2,178	9.7% of Patients Screened
Employees	215	7.2% of Employees Screened
Total Tuberculous	1,474	5.8% of Total Screened
Patients	1,379	6.2% of Patients Screened
Employees	95	3.2% of Employees Screened
Total Other Pathology	615	2.4% of Total Screened
Patients	586	2.6% of Patients Screened
Employees	29	1.0% of Employees Screened
Total Negative	23,262	91.8% of Total Screened
Patients	20,422	91.2% of Patients Screened
Employees	2,840	95.8% of Employees Screened

TABLE III

Number and Percentage of Cases Discovered—By Stage of Disease

	Per Cent of Total Screened
Total Tuberculous	1474	5.8%
Total Tuberculous Patients	1379	6.2%
Total Tuberculous Employees	95	3.2%

		Number	Percentage	100.0% Percentage
Primary with Activity	Patients	5	0.4%	0.3%
	Employees	-----	-----	
Minimal	Patients	766	55.5%	56.0%
	Employees	60	63.1%	
Moderately Advanced	Patients	362	26.2%	25.4%
	Employees	13	13.7%	
Far Advanced	Patients	78	5.7%	5.4%
	Employees	1	1.1%	
Reinfection, Stage Unknown	Patients	28	2.0%	2.3%
	Employees	6	6.3%	
Pleurisy with Effusion	Patients	17	1.2%	1.2%
	Employees	-----	-----	
Suspected Tuberculosis	Patients	122	8.9%	9.3%
	Employees	15	15.8%	
Suspected Silicosis with Infection	Patients	1	0.1%	0.1%
	Employees	-----	-----	

TABLE IV

Number and Percentage of Cases Discovered—By Activity

Active	Patients	131	9.8%	11.3%
	Employees	20	1.5%	
Questionably Active	Patients	996	74.5%	77.9%
	Employees	46	3.4%	
Inactive	Patients	130	9.7%	10.8%
	Employees	14	1.1%	
	Total	1337	100.0%	100.0%
Suspected Tuberculosis		137		
Total Tuberculosis		1474		

TABLE V

Number and Percentage of Cases of Tuberculosis and Non-Tuberculous Pathology—By Color

		White	Colored	Other
Screened	Total	23,687	1,655	9
	Patients	20,749	1,629	9
	Employees	2,938	26	0

		No.	Per Cent of Whites Screened	No.	Per Cent of Colored Screened	No.	Per Cent of Others Screened
Tuberculous	Total	1,397	5.9%	76	4.6%	1	11.1%
	Patients	1,305	6.3%	73	4.5%	1	11.1%
	Employees	92	3.1%	3	11.5%	0	———
Non-Tuberculous Pathology	Total	538	2.3%	77	4.6%	0	———
	Patients	509	2.5%	77	4.7%	0	———
	Employees	29	1.0%	0	———	0	———
Negative	Total	21,752	91.8%	1,502	90.8%	8	89.9%
	Patients	18,935	91.3%	1,479	90.8%	0	———
	Employees	2,817	———	23	88.5%	8	89.9%

TABLE Va

Number and Percentage of Cases Discovered All Stages of the Disease—By Color

			Number	Percentage	100.0% Percentage
Primary with Activity	White	Patients	5	0.4%	
		Employees	———	———	0.3%
	Colored	Patients	———	———	
		Employees	———	———	
Minimal	White	Patients	736	56.4%	
		Employees	57	62.0%	
	Colored	Patients	29	39.7%	56.0%
		Employees	3	100.0%	
	Chinese	Patient	1	100.0%	
Moderately Advanced	White	Patients	345	26.4%	
		Employees	13	14.1%	25.4%
	Colored	Patients	17	23.3%	
		Employees	———	———	
Far Advanced	White	Patients	71	5.4%	
		Employees	1	1.1%	
	Colored	Patients	7	9.6%	5.4%
		Employees	———	———	
Reinfection, Stage Unknown	White	Patients	24	1.8%	
		Employees	6	6.5%	2.3%
	Colored	Patients	4	5.5%	
		Employees	———	———	
Pleurisy with Effusion	White	Patients	14	1.1%	
		Employees	———	———	1.2%
	Colored	Patients	3	4.1%	
		Employees	———	———	
Suspected Tuberculosis	White	Patients	109	8.4%	
		Employees	15	16.3%	9.3%
	Colored	Patients	13	17.8%	
		Employees	———	———	
Suspected Silicosis with Infection	White	Patients	1	0.1%	
		Employees	———	———	0.1%
	Colored	Patients	———	———	
		Employees	———	———	

ommendations were sent to the superintendents of the respective institutions with the advice that the cases of tuberculosis should be reported to the health district of residence of the patient in order to facilitate follow-up studies among family contacts.

MORTALITY AND MORBIDITY ANALYSIS

In order to obtain a basis for study of the tuberculosis problem in the mental schools and hospitals in the state, a review of the deaths occurring in 14 state institutions during the five-year period January 1, 1941, to December 31, 1945, was made: 1,094 or 12.86 per cent of all deaths occurring during this period were due to tuberculosis. In 1943, there were 128 known cases in these institutions; in 1944, there were 148 known cases or roughly 0.6 case per death; and in 1945, shortly after the start of the survey, 351 cases were known or 1.55 cases per tuberculosis death. (Table I.)

The total number of individuals examined was 25,351, of whom 22,387 were patients and 2,964 were employees. X-ray evidence of tuberculosis (non-calcified primary, reinfection-type tuberculosis, pleurisy with effusion, and silicosis with infection) was found in 1,474 cases or 5.8 per cent of the total; 615 cases or 2.4 per cent of the total screened revealed evidence of non-tuberculous lung pathology. (Table II.)

Of the 1,474 cases of tuberculosis, 1,379 or 6.2 per cent were patients and 95 or 3.2 per cent were employees. Distribution of tuberculosis by stages occurred among the resident patients and employees in approximately the same relation in which it is found in surveys of general population groups, that is 56 per cent were minimal, 25.4 per cent were moderately advanced, and 5.4 per cent were far advanced. (Table III.)

Of the 1,337 cases, 151 or 11.3 per cent were diagnosed as active on the basis of single film evidence of ulceration or cavitation, 1,042 or 77.9 per cent were considered questionably active and required further observation and diagnostic follow-up and 144 or 10.8 per cent were inactive. Films which were technically unsatisfactory, but revealing shadows considered suspicious were designated as suspected tuberculosis and immediate re-X-ray advised; there were 137 of these cases. (Table IV.)

The total of 25,351 persons X-rayed was composed of 23,687 or 93.4 per cent white, 1,655 or 6.5 per cent negro, and 9 persons classified in other racial groups. Colored patients showed an incidence of 4.3 per cent as compared with an incidence of 6.4 per cent among white patients. However, far advanced disease in the colored was 9.6 per cent and in the white patients was 5.4 per cent. (Tables V and Va.)

The prevalence of tuberculosis in the females was somewhat less than in the males. Of the total cases, 607 or 41 per cent were females and 867 or 59 per cent were males; 52.3 per cent of tuberculosis in the male patients and 60.3 per cent in the female patients was in the minimal stage. Advanced disease was noted in 34.5 per cent of the male patients and 28.2 per cent of the females. (Table VI.)

Distribution of tuberculosis by age groups revealed a striking similarity between the occurrence of the disease in the patients and the employees; 71 per cent of the patients and 71.5 per cent of employees with tuberculosis were in the age groups over 45 years. The gradual increase in percentage of cases discovered through the age groups suggests the importance of the effect of prolonged residence and consequent exposure to unknown sources of infection. (Table VII.)

DISCUSSION

The findings in this survey have served to accentuate the need for an adequate tuberculosis control program for the mental institutions in the state of Ohio.

Studies by Pollack, Hummel, and Turow,[1] Burns,[2] Bogen, Tiez, and Grace,[3] Plunkett and Tiffany,[4] and Hilleboe, Haas, Palmer, and Gardner[5] have shown that tuberculosis in mental institutions is more prevalent than mortality statistics would indicate. The percentage of cases discovered by means of tuberculosis surveys varies considerably according to different authors. Plunkett and Tiffany[4] note 9.1 per cent tuberculous among 3,176 patients and 3.4 per cent among 794 employees at Willard State Hospital. Wicks[6] found 7.3 per cent of 10,816 patients with tuberculosis and an additional 7.5 per cent with definitely or probably arrested lesions; he records 2.1 per cent tuberculous among employees. Our survey of 25,351 persons with photofluorographic equipment revealed a percentage of 6.2 per cent tuberculous among 22,387 patients and 3.2 per cent tuberculous among 2,964 employees. These rates together with the findings of a greater percentage of tuberculosis in the older residents suggest that a large part of the affected group contract their infection during their residence in the institution.

Because of the prolonged intimate association which is a part of institutional segregation, exposure from unknown and unisolated infectious cases must occur. Tuberculosis among employees merits the serious consideration of hospital authorities. Whatever and wherever the source of an employee's tuberculous infection it can hardly be denied that harmful exposure to unrecognized cases occurs in the institutions. Through release of unknown communicable cases on probationary visits or by discharge, the opportunity for exposure to the disease by the general population becomes a problem of first importance. Protection of the physical health

TABLE VI

Number and Percentage of Cases Discovered, All Stages of the Disease—By Sex

		Number	Percentage	100.0% Percentage
Primary with Activity	Male Patients	5	0.5%	
	Male Employees	-----	-----	0.3%
	Female Patients	-----	-----	
	Female Employees	-----	-----	
Minimal	Male Patients	422	52.3%	
	Male Employees	38	64.5%	56.0%
	Female Patients	344	60.3%	
	Female Employees	22	61.1%	
Moderately Advanced	Male Patients	220	27.2%	
	Male Employees	9	15.2%	25.4%
	Female Patients	142	24.9%	
	Female Employees	4	11.1%	
Far Advanced	Male Patients	59	7.3%	
	Male Employees	-----	-----	5.4%
	Female Patients	19	3.3%	
	Female Employees	1	2.8%	
Reinfection Stage Unknown	Male Patients	20	2.5%	
	Male Employees	3	5.1%	2.3%
	Female Patients	8	1.4%	
	Female Employees	3	8.3%	
Pleurisy with Effusion	Male Patients	11	1.4%	
	Male Employees	-----	-----	1.2%
	Female Patients	6	1.0%	
	Female Employees	-----	-----	
Suspected Tuberculosis	Male Patients	70	8.7%	
	Male Employees	9	15.2%	9.3%
	Female Patients	52	16.7%	
	Female Employees	6	9.5%	
Suspected Silicosis with infection	Male Patients	1	0.1%	
	Male Employees	-----	-----	0.1%
	Female Patients	-----	-----	
	Female Employees	-----	-----	

of the patient, mentally normal or psychotic, is a fundamental responsibility, yet this pool of infection has been allowed to increase abundantly and it can only be dried up through systematic surveys applied in this direction.

The apparent discrepancy between morbidity and mortality rates of white and colored patients merits special attention. Data at hand reveal a tuberculosis death rate among colored which greatly exceeds that of the white population, the ratio in Ohio being approximately 4 to 1. Contrasted with this, the incidence of tuberculosis among the colored patients is in the proportion of 2 to 3 for white patients in mental institutions.

Disproportion in numbers can hardly account for this discrepancy. Edwards[7] records a prevalence rate among prison Negro inmates amounting to less than one-half the rate observed in white individuals. However, the well-known fact that tuberculosis in the colored is frequently an acute, fulminating disease suggests that a large proportion of the colored tuberculous are undoubtedly discovered and isolated at an early date. The occurrence of relatively benign disease in the colored is infrequent and this seems to be borne out by the findings of advanced disease among the colored in our survey in nearly twice the percentage as that observed in white patients.

CONCLUSION

Tuberculosis in mental institutions presents a special problem both from the administrative and the public health standpoint. Administratively, it is necessary to know the extent and character of the disease in order that provision can be made for the proper disposition of the cases and the protection of institutional employees and the public. Epidemiologically, early recognition and isolation of infectious cases must be made to prevent further spread.

Fundamentally the problem stems from (1) the committment of individuals with tuberculosis and (2) the development of new cases while the individuals are in residence. Cases can be detected on entrance to the institution through routine screening X-rays of all admis-

sions and pre-placement X-rays of employees. Cases that develop during residence in the institution can be found through periodic routine screening of the entire institutional personnel. Active, infectious cases found on admission or during periodic checkups should be isolated in hospital facilities especially provided for this purpose. A large percentage of cases will not require immediate hospitalization, but will need

TABLE VII

Number and Percentage of Cases Discovered All Stages of the Disease—By Age Group

Patients:		
5 to 14	11	0.8%
15 to 24	44	3.2%
25 to 34	199	8.6%
35 to 44	224	16.3%
45 to 54	299	21.7%
55 to 64	357	25.9%
65 or over	323	23.4%
Unknown	2	0.1%
Total	1379	100.0%
Employees:		
5 to 14	1	1.1%
15 to 24	4	4.2%
25 to 34	4	4.2%
35 to 44	17	17.9%
45 to 54	25	26.3%
55 to 64	25	26.3%
65 or over	18	18.9%
Unknown	1	1.1%
Total	95	100.0%
Total:		
5 to 14	12	0.8%
15 to 24	48	3.3%
25 to 34	123	8.3%
35 to 44	241	16.4%
45 to 54	324	22.0%
55 to 64	382	25.9%
65 or over	341	23.1%
Unknown	3	0.2%
Total	1474	100.0%

further observation in order to determine the activity and infectiousness of the disease. These persons should be isolated in a separate tuberculosis unit, where further diagnostic studies can be made and their exact status established. When it is found that these cases no longer constitute a public health problem they may be returned to their respective institutions.

Treatment of the mentally ill patient with tuberculosis is essentially the same as that prescribed for the mentally normal patient. Rest is the basic therapeutic measure and should be obtained, if necessary, by administration of sedatives. Sputum conversion is one of the objectives of treatment and collapse therapy, as indicated, can and should be utilized to achieve this goal.

BIBLIOGRAPHY

1. Pollack, M., Hummel, A. V., and Turow, I. L.: Tuberculosis In Mental Hospitals. Am. Rev. Tuberc., 43, 373, 1941.
2. Burns, H. A.: A Study of the Incidence of Tuberculosis in State Institutions in Minnesota. Am. Rev. Tuberc., 33, 813, 1936.
3. Bogen, E., Tiez, E. B., and Grace, M. F.: Tuberculosis and Mental Disease. Am. Rev. Tuberc., 30, 353, 1934.
4. Plunkett, R. E., and Tiffany, W. F.: A Tuberculosis Control Program. Am. Jr. Publ. Health, 31, 769, 1941.
5. Hilleboe, H. E., Haas, R. B., Palmer, C. E., and Garner, W. R.: Tuberculosis Case Findings in Institutional Populations. Am. Jr. Publ. Health, 32, No. 5, 1942.
6. Wicks, C. A.: Tuberculosis Prevention and Treatment in Ontario Mental Hospitals. Amer. Psychiatric Assn. Meeting, May, 1939.
7. Edwards, H. R.: Tuberculosis Case Finding. Am. Rev. Tuberc. (supplement), 41, 96, 1940.

The Doctor Treats the Patient

This field of functional illness or psychosomatic medicine as presently described may be new in terminology, but as a concept it is old and fundamental. It is now newly characterized and emphasized. It was developing very rapidly by means of clinical practice and research by psychiatrists and in many leading medical clinics prior to World War II. The experience of the past decade was brought sharply into focus by the war, and physicians found that it helped a huge number of patients. The acute etiology of war brought out what chronic etiology in emotional maladjustment had struggled to show before in civilian life.

About fifty thousand physicians were actively connected with some branch of the armed service. They found that of the medical conditions in and out of army hospital beds, 40 per cent were due entirely to nonorganic etiology of functional origin. They realized that dismissal of such patients with a label of neuropsychiatric was neither a solution for the patient or the army, nor satisfactory to the conscientious physician. Most of these patients were sick but organically sound. For the first time therapy was a "must", and the few skilled psychiatrists had the opportunity of demonstrating the wide effectiveness of psychotherapy. Perhaps it took World War I to make psychiatrists discover psychiatry, but World War II made medicine as a whole understand psychiatry and psychotherapy.

The teaching of the principles of therapy for functionally ill patients is no longer solely possessed by the psychiatric specialist. In fact, there is some reason to believe that the internist and other specialists may better aid their students in the practice of medicine by developing a concept of the importance of psychotherapy without special reference to its psychiatric origin or association. Psychotherapy has always been an integral part of the therapeutic endeavor of any high grade physician.—Lauren H. Smith, M.D., Philadelphia, Jr. of Iowa State Med. Society, Vol. XXXVI, No. 10, October, 1946.

Ohio Medical Indemnity, Inc., Starts Business in Columbus Area; 55 Counties Now Covered by O.S.M.A. Plan

EXTENSION of the activities of Ohio Medical Indemnity, Inc., the prepaid medical expense plan sponsored by the Ohio State Medical Association, into another area of Ohio has been announced by Mr. Charles H. Coghlan, executive vice-president of the company.

Subscribers are now being enrolled in the 29-county area covered by Central Hospital Service of Columbus, the Columbus Blue Cross plan. An agreement has been established between Ohio Medical Indemnity, Inc., and the Central Hospital Service, whereby the latter will perform certain administrative services in connection with the issuance and distribution of Ohio Medical Indemnity contracts in the new territory. Ralph W. Jordan, Executive Director of Central Hospital Service, has been named agent for Ohio Medical Indemnity in the area.

The enrollment policy which has been in effect in the Cincinnati and Toledo areas, covering 26 counties, will be followed in the Columbus area. Subscribers will be enrolled only in groups and they will be, for the time being, holders of Blue Cross hospitalization contracts.

With this latest expansion, Ohio Medical Indemnity is now covering 55 counties of the state, plus one township in Tuscarawas County, which is in the Columbus area.

According to Mr. Coghlan, the business of the company in the Cincinnati and Toledo areas is showing a steady growth. As of October 31, appproximately 65,000 subscribers had enrolled in the counties covered by these areas, 55,000 of whom are in the Cincinnati area, and 10,000 in the Toledo district. Claims paid up to October 31 amounted to $45,347.50.

Counties in the Columbus area include: Athens, Champaign, Coshocton, Crawford, Delaware, Fairfield, Fayette, Franklin, Gallia, Guernsey, Hocking, Jackson, Knox, Lawrence, Licking, Logan, Madison, Marion, Meigs, Morgan, Morrow, Muskingum, Perry, Pickaway, Pike, Ross, Union, Vinton, and Wyandot. Oxford township in Tuscarawas county also will be covered.

In the Cincinnati district these counties are covered: Hamilton, Clermont, Brown, Adams, Highland, Clinton, Warren, Butler, Preble, Montgomery, Greene, Clark, Miami, and Darke.

Counties in the Toledo area include: Lucas, Wood, Fulton, Henry, Williams, Defiance, Paulding, Ottawa, Sandusky, Seneca, Erie, and part of Huron.

Negotiations are under way with the Blue Cross Plans of Akron and Canton for extension of coverage of Ohio Medical Indemnity in those sections of the state.

Inquiries regarding the activities of Ohio Medical Indemnity may be sent to the home office of the company, Room 801, Hartman Theater Building, Columbus 15, or to the following: Central Hospital Service, 79 East State Street, Columbus 15; Hospital Service Association of Toledo, 441 Huron Street, Toledo 4; Hospital Care Corporation, Wm. Howard Taft Road at Woodburn Avenue, Cincinnati 6.

Now Is the Time To Get Your Hotel Space for 1947 Annual Meeting, May 6-8, Cleveland

IT isn't too early to make hotel reservations for the 1947 Annual Meeting of the Ohio State Medical Association, to be held in Cleveland, May 6, 7, and 8.

The scientific sessions and the technical exhibits will be located in the spacious Cleveland Municipal Auditorium. Meetings of the House of Delegates will be held at the Hotel Cleveland, headquarters hotel, also headquarters for the Woman's Auxiliary.

In order to insure obtaining the type of accommodations you desire in the hotel of your choice, make a selection now from the list of hotels appended. Complete the reservation blank at the bottom of the page and **mail it directly** to the hotel management.

You'll look forward to the meeting with greater anticipation if you have a confirmed hotel reservation in your file.

NAME AND LOCATION	No. of Rooms	Single	Double	Double Twin Beds
CLEVELAND Public Square (Headquarters Hotel)	1000	$3.00-$7.00	$4.50-$9.00	$6.00-$12.00
ALLERTON Chester at E. 13th St.	550	2.65- 4.50	4.00- 6.50	5.00- 7.50
AUDITORIUM St. Clair at E. 6th St.	300	2.00- 3.50	4.00- 6.00	4.50- 7.00
CARTER Prospect at E. 9th St.	600	4.00- 7.00	6.00- 8.00	7.00- 9.00
HOLLENDEN 610 Superior Ave., NE	1000	3.00- 5.00	4.50- 6.50	5.00- 12.00
OLMSTED Superior at E. 9th St.	250	3.00- 5.00	5.00- 7.00	6.00- 8.00
STATLER Euclid at E. 12th St.	1000	3.00- 6.00	5.00- 8.00	5.00- 8.00

HOTEL RESERVATION BLANK

Mail this coupon to hotel selected

Manager _____ Hotel, Cleveland, Ohio.

You are requested to reserve the following accommodations during the period of the Annual Meeting of the Ohio State Medical Association, May 6, 7, and 8, 1947, or for such other period as may be indicated herein.

☐ Single Room with bath ☐ Double Room with bath Price: _____

☐ Twin Bed Room with bath ☐ Suite

Arriving May _____ at _____ A.M. _____ P.M.

PLEASE VERIFY MY RESERVATION.

Name _____

Address _____

Survey of Hospital Facilities and Needs in Ohio To Be Started Soon; Methods for Study Summarized

THE survey of hospital facilities and needs in Ohio, provided for in legislation enacted by the 96th Ohio General Assembly, is scheduled to begin December 2 and may be completed within a year, according to an outline of the project discussed and approved by the Ohio Hospital Advisory Council, meeting October 30 at the Deshler-Wallick Hotel, Columbus.

It will constitute the first step toward meeting the requirements of Public Law 725, the Federal Hospital Construction Act (Hill-Burton Act) for Ohio's participation in a matching arrangement which will permit non-profit institutions or voluntary groups to request Federal aid amounting to one third of the cost to construct a hospital or health center. The survey will also serve as a guide for future hospital development on a sound basis within the state.



ADVISORY COUNCIL APPOINTED

The Ohio Department of Health was designated by the legislature as the state agency through which the survey will be conducted and the 26-member advisory council, representing the medical profession, hospital administrators, and consumers of hospital care, was appointed by the governor to guide the activities of the department.

An executive committee of 12 members of the advisory council to function in the interim between its meetings has been appointed to serve under the chairmanship of Dr. Roger E. Heering, State Director of Health.

ADDITIONAL LEGISLATION NECESSARY

Action was taken by the council to initiate two pieces of legislation for consideration of the 97th General Assembly, convening in January, 1947, which are prerequisites to the hospital construction program. One of these will be a bill establishing minimum standards of operation of hospitals constructed with Federal funds. This licensing procedure, as required in Public Law 725, was specified in lieu of Federal control "as a guarantee that Federal funds be wisely spent". The state must enact such legislation before July 1, 1948, in order to be eligible to participate.

The other bill will give the advisory council legal status. At present, it can only advise on survey matters. There is no agency set up to administer the findings of the survey once it is completed nor to carry out the construction phase of the law. This bill will authorize the Ohio Department of Health to administer the actual details of the program with guidance from the advisory council.

DR. TURNER TO DIRECT SURVEY

The Ohio Department of Health, as the official survey agency, has selected Dr. E. V. Turner, Columbus, to conduct the actual work of the survey. Dr. Turner is now completing the Ohio Study of Child Health Services, sponsored by the American Academy of Pediatrics. Dr. Turner's title is "Director of Study". He will be assisted by two inventory supervisors, a research supervisor, and the four district councils of the Ohio Hospital Association.

WILL DELIVER 40-PAGE QUESTIONNAIRE

A field staff of six men will begin delivery of a 40-page questionnaire to each hospital in the state having more than 25 beds on December 2. This staff has been fully trained in technicalities of the work and will explain the questionnaire to hospital administrators. A period of 14 days will be granted each administrator to complete the questionnaire. Two weeks after delivery, a member of the field staff will call at the hospital for the questionnaire. It will then be referred to the director of study for review and editing. For hospitals of less than 25 beds, and other small institutions, a short form will be used.

A.H.A. TO TABULATE ANSWERS

The advisory council hopes to have all questionnaires completed by March 1, 1947. After they have been reviewed by the director of study, they will be forwarded to the American Hospital Association where the information will be transferred to tabulating machine cards. The cards will be tabulated and the resulting information returned for analysis by the advisory council.

The director of study will compile from the tabulation results a preliminary report of the

state-wide picture about November 1, 1947. Later, a more detailed report including the local statistics will be compiled. The hospitals will not be identified in the report.

PLAN MUST BE APPROVED

The Ohio Department of Health has announced that applications for funds can not be entertained until the survey has been completed and the resultant plan for expansion has been approved by the Surgeon General of the U.S. Public Health Service. "Applications will then be considered entirely on their individual merits in the light of existing needs and with relation to a planned pattern for the development of such facilities as are regarded as essential to a sane program for providing necessary hospital beds for the use of our entire people", a statement issued by Dr. Heering stated.

Although the Congress has as yet made no appropriation for hospital construction as authorized by the Hill-Burton Act (Public Law 725), it is anticipated that appropriations will be made some time before June 30, 1947. Preliminary information indicates that Ohio will receive about $2,700,000 for each of five years. The Federal funds can be held over for one year only.

During the meeting of the advisory council it was made clear that it is not in a position to tell any community not to build a hospital and that where a survey has been completed and accepted by the community, not affecting any other area, they should not be told to stop. On the other hand, it is felt that whenever possible communities should be asked to wait until the complete survey of the state is made.

ADVISORY COUNCIL LISTED

Members of the advisory council include Roger E. Heering, M.D., Chairman, Columbus; Harry C. Eader, Secretary, Columbus; Less S. Lanpher, Cleveland; Mons. M. F. Griffin, Cleveland; Guy J. Clark, Cleveland; Celia Cranz, R.N., Akron; David A. Tucker, M.D., Cincinnati.

George A. Woodhouse, M.D., Pleasant Hill; A. R. Mangus, Ph.D., Columbus; William S. Konold, Columbus; M. F. Steele, M.D., Cincinnati; W. L. Benfer, Toledo; Mrs. Helen Houghton, Columbus; Fred Phillips, M.D., Zanesville; Robert M. Porter, Columbus; Harry W. Culbreth, Columbus.

W. G. Leutner, Cleveland; Joseph T. Wearn, M.D., Cleveland; Frank F. Tallman, M.D., Columbus; Charles F. Kettering, Dayton; L. J. Greenwald, D.D.S., Columbus; Grove Patterson, Toledo; Joseph W. Fichter, Columbus; Charles H. Wesley, Ph.D., Wilberforce; Mrs. Charles W. Hoke, Sandusky; Herbert D. Chamberlain, M.D., McArthur.

One Physician Elected to Congress, Two to Ohio Legislature

Three Ohio physicians will resume their legislative duties in January, having been successful in contests for re-election on Nov. 5. All three are Republicans and members of the Ohio State Medical Association.

Dr. Frederick C. Smith, Marion, was re-elected to the United State Congress from the Eighth District, which includes Crawford, Hancock, Hardin, Marion, Morrow, and Wyandot counties. A former mayor of Marion, Dr. Smith was first elected to the Congress in November, 1938, and will begin his fifth term when the 80th Congress convenes in January, 1947. He was a member of the Banking and Currency Committee in the 79th Congress.

Re-elected representative from Athens County to the State Legislature, Dr. E. LeFever, Glouster, will be the "dean" of the 97th Ohio General Assembly, which convenes at Columbus on January 6. A veteran of 24 years experience in the State House, Dr. LeFever first represented Athens County in the legislature in 1900-1901. He held the same post in 1904-1905; 1921-1922; 1933-1934 1939-1946, and was a member of the State Senate from the Ninth-Fourteenth District during the years 1923-1930. In the 95th General Assembly, Dr. LeFever was chairman of the House Health Committee and a member of the Mines Committee and the Finance Committee (Educational Section).

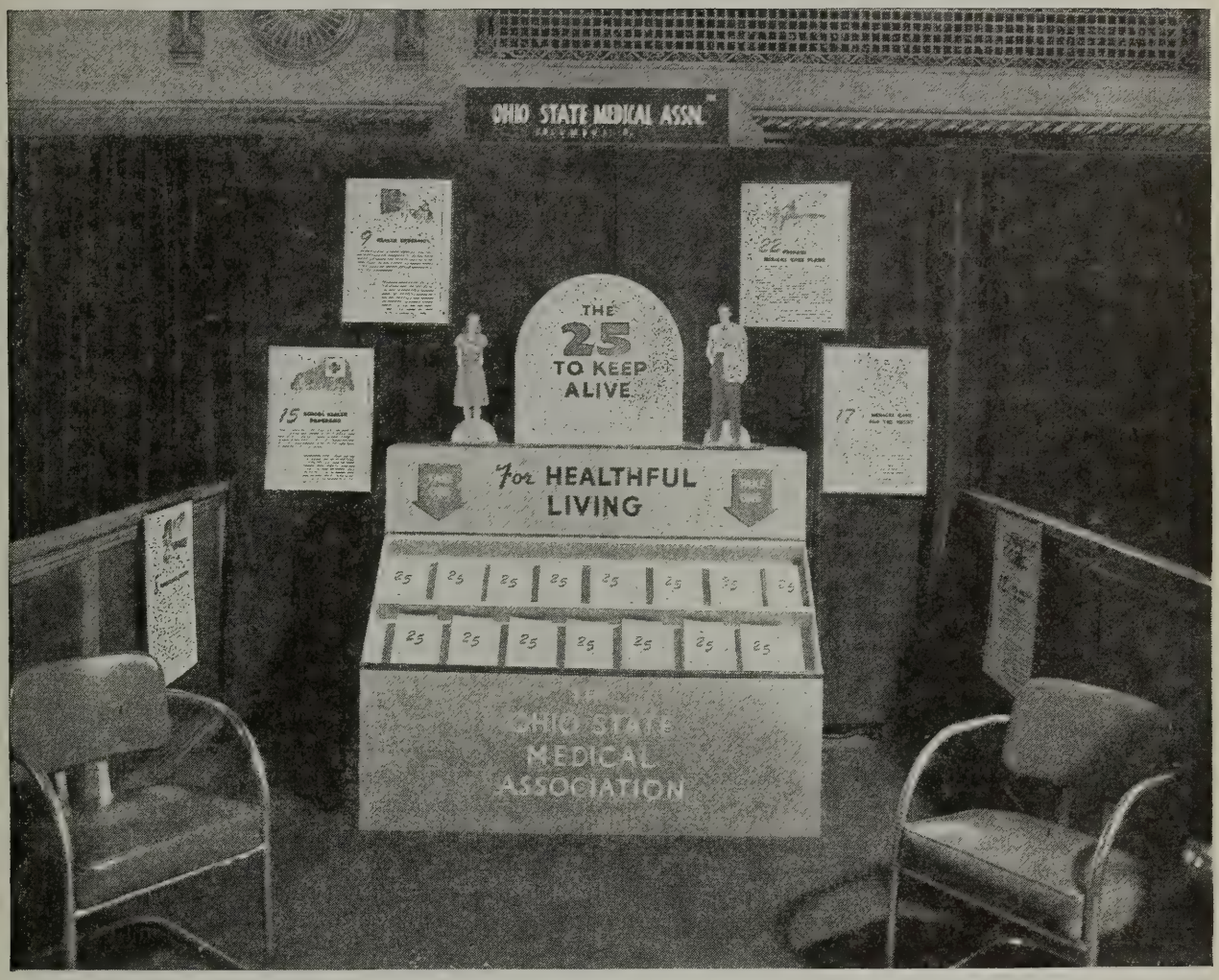
Dr. C. A. Craig, Cambridge, was re-elected representative from Guernsey County, after previously serving two consecutive terms, 1943-1946. At the last session Dr. Craig was a member of the Health, Highways and Mines Committees.

Among the successful candidates also was Mrs. Opal J. Mundy, Toledo, one of the five Republican members of the Ohio House of Representatives from Lucas County. A former member of the Toledo Board of Education, Mrs. Mundy is the wife of Dr. Carll S. Mundy and the mother of Dr. William N. Mundy, III. During the 96th General Assembly, she was a member of the Health, Education and Agriculture committees.

Limited Practitioners Excluded

According to Opinion No. 1350, issued by Attorney General Hugh Jenkins under the date of November 13, chiropractors and other limited practitioners are not eligible to be paid out of relief funds for the care of indigent persons, inasmuch as they are not physicians and surgeons as defined by the Ohio Medical Practice Act. The poor relief law authorizes the use of relief funds for medical care if the services are rendered by a physician or surgeon.

O. S. M. A. "Health Program For Ohio" Display



OVER 2,000 copies of the booklet "The 25 To Keep Alive", describing the Ohio State Medical Association's health program for Ohio were distributed from the Association's booth in the Scientific Exhibit at the 74th Annual Meeting of the American Public Health Association held in the Cleveland Municipal Auditorium, Nov. 12-14.

As pictured above, the booth contained a flashing-light display unit with shelves on which copies of the booklets were placed.

The six posters shown are tinted enlargements from the booklet of six of the 25 points, i.e., tuberculosis control; school health programs; health education; prepaid medical care plans; and medical care of the needy.

Representatives of the Association's Department of Public Relations were at the booth to answer questions concerning the program, and to hand out the booklet. Comment generally was complimentary concerning the constructive program and the attractive brochure.

The exhibit was shown also at the Ohio Welfare Conference, the Deshler-Wallick Hotel, Columbus, Nov. 16-20, when 1,250 copies of the booklet were handed out.

Over 50,000 copies of "The 25 To Keep Alive" have been distributed. Many Ohio physicians are presenting copies to members of luncheon clubs, P.T.A.'s and other civic organizations. Requests for a supply should be adressed to the State Headquarters Office, 1005 Hartman Theater Bldg., Columbus 15.

Ex-Medical Officers Being Asked for Comments on War Experiences and for Suggestions on How Physicians Should Be Utilized in any Future Emergency

ALL Ohio physicians who served in the armed forces or full-time government services during World War II will be given an opportunity to express their frank reactions to their war-time service and to offer suggestions regarding the utilization of medical personnel in the event of another national emergency.

Two methods have been arranged for polling members of the medical profession on this important matter:

1. A comprehensive questionnaire is being mailed to more than 45,000 discharged medical officers of World War II by the Committee on National Emergency Medical Service of the American Medical Association, headed by Dr. Edward L. Bortz, Philadelphia.

2. The Ohio State Medical Association has established a Committee on National Emergency Medical Service which will act as a clearing house for suggestions and criticisms of Ohio discharged medical officers.

The A.M.A. questionnaire is being mailed from the A.M.A. headquarters at Chicago. It should be returned to that office as soon as possible—within at least a month following receipt. The results will be tabulated and analyzed in detail.

The Ohio committee is composed of the following: Dr. C. C. Sherburne, Columbus, chairman; Dr. Robert Conard, Wilmington; Dr. E. A. Ockuly, Toledo; Dr. Richard L. Meiling, Cleveland; Dr. William O. Ramey, Cincinnati; Dr. Harry R. Huston, Dayton; Dr. Robert Zollinger, Columbus; Dr. Carl R. Damron, Mansfield; Dr. Cyrus R. Wood, Port Clinton.

The committee of the Ohio State Medical Association will review information and correspondence already on file and will secure additional data from Ohio physicians regarding their war-time experiences. This material will be studied and analyzed and recommendations subsequently submitted to the A.M.A. committee.

Efforts will be made by the committee also to collect helpful data from physicians who remained on the home-front. In this way the committee hopes to be able to compile recommendations covering not only military services but also as to how civilian and industrial medical services, medical education, medical research, etc., should be organized to meet problems which would arise during another national emergency.

"Since the results of the questionnaire will serve as a useful guide in preparing for any new national emergency, the committee urges all the returning medical officers to express frankly, fully, and completely their reaction to military service", Dr. Bortz said in discussing the questionnaire.

Editor's Note:

The accompanying announcement is undoubtedly the most important made to the medical profession since the end of World War II.

For this reason, Ohio physicians are urged to cooperate in every possible way.

Those who served in the armed forces or government services during the war should complete the A.M.A. questionnaire and return it promptly. Covering letters should be written to supplement answers given on the blank.

Also, ex-medical officers and those who remained in civilian or industrial practice, in medical education capacities and took an active part in emergency services and programs on the home-front should submit their criticisms and suggestions to the committee of the State Association.

Here is an opportunity for physicians to tell what they believe was wrong with methods used for utilizing the services of the medical profession doing World War II and to offer recommendations on how medical personnel should be organized and utilized in event of another national emergency.

LETTER FROM DR. LULL

The following letter, signed by Dr. George F. Lull, secretary and general manager of the A.M.A., in behalf of the committee will accompany each questionnaire:

"The House of Delegates of the American Medical Association in December, 1945, created a committee to study the over-all needs and utilization of medical skills and resources of the nation

in the case of an emergency. The House passed the following resolution:

"'. . . that the Association undertake a critical study of the duties of medical officers during the war just passed, with special reference to (1) opportunities for study, research, and actual treatment of the sick; (2) rotation of medical assignments; (3) quasi-medical duties for which technicians and specially trained enlisted personnel might replace physicians . . .

"'. . . and appoint a special committee to study by means of questionnaires sent to medical officers on release from active duty . . .'

"The Board of Trustees has appointed a National Emergency Medical Service Committee and instructed it to undertake the study and prepare plans as described in the action of the House of Delegates.

"A pilot questionnaire was sent to 1,000 former medical officers, selected at random. The response was surprisingly large. A total of 470, or 47 per cent, of those questionnaires were carefully filled out and returned. Certain technical defects in the pilot questionnaire form were noted and the revised questionnaire enclosed herewith was developed. It is being sent to all former medical officers, including those who received the pilot questionnaire.

"The Committee is a fact finding board and hopes to make recommendations that will lead to better utilization of medical skills and resources in a future emergency. Your help in this will be appreciated. A stamped envelope is enclosed for your early return of the completed questionnaire. You are cordially invited to write a covering letter if the questionnaire has omitted points which you deem significant."

Dr. Bortz said that the committee feels that its final analysis and recommendations should cover not only the military services, but also other governmental agencies, industry, medical education, research, and civilian medical care.

EASY METHOD PROVIDED

The A.M.A. committee, in so far as possible, has provided check lists in this questionnaire. This makes it possible for the doctor merely to check the proper item and avoid taking the time to write out his answers.

Some of the questions will require written explanations, however. For example: What important features of training were not sufficiently stressed? What in your opinion should be included in an ideal training program? If there was waste of personnel in your unit, please state how personnel could have been used effectively. What suggestions have you about methods of assignment of medical officers in the event of another military emergency?

Dr. Bortz stressed the desirability of deliberation on the part of every physician in answering the questions. "The objective sought", he said, "can be best attained by careful consideration of each and every question."

MEMBERS OF COMMITTEE

In addition to Dr. Bortz, the National Emergency Medical Service Committee is composed of Harold S. Diehl, M. D., University of Minnesota, Minneapolis; Perrin H. Long M. D., Baltimore; Harold C. Lueth, M.D., University of Nebraska, Omaha; O. O. Miller, M. D., Louisville, Ky.; James C. Sargent, M.D., Milwaukee; and V. C. Tisdal, M.D., Elk City, Oklahoma.

A.M.A. Plans for Centennial Session at Atlantic City

The American Medical Association will celebrate its centennial in Atlantic City, June 9 to 13, 1947.

Arrangements call for making it one of the greatest and most interesting medical assemblages ever convened.

Each of the scientific sections of the American Medical Association has been authorized to secure a distinguished speaker from abroad and to include also in its program a review of medical progress in the specialty concerned for the hundred-year period. Each of the general scientific meetings will provide for the presentation of three papers constituting reviews of the advancement in the fields discussed, followed by panel discussions on such subjects as the modern management of heart disease, emergency surgery and antibiotics in therapy.

Another highlight of the centennial session is the utilization of Sunday, June 8, as a special public health day. A religious program is being arranged with representatives of the leading faiths of our country. This will be held in the great auditorium in convention hall and will no doubt be broadcast on one of the national chains. At the same time congregations assembled for religious services elsewhere throughout the nation will be given messages regarding the advancement of medical science and the improvement in the public health that have occurred during the hundred-year period.

The division of motion pictures in the headquarters office of the American Medical Association is at present engaged in the development of two motion pictures dealing with the lives of the distinguished American physicians of the period concerned and with the evolution of motion pictures in medical teaching. The first public showings are contemplated for Monday evening, June 9.

A general practitioner for the past 30 years, Dr. Guy Aud, Louisville, was elected president of the Kentucky State Medical Association at its 96th annual meeting.

Procedure for Out-Patient Treatment and Hospitalization For Veterans with Claims Pending Is Clarified

CIRCULAR No. 215, recently issued by the Veterans Administration, clarifies many of the questions which have arisen in connection with the proper procedure for out-patient treatment or emergency hospitalization for veterans pending adjudication of their claims for compensation for purported service-connected disability.

Under the provisions of Circular No. 215 as amended, when a veteran requests out-patient medical treatment or emergent hospitalization and has filed a claim for compensation or pension which has not been adjudicated or he has not filed a claim for these benefits, the chief medical officer or his designate at a regional office, center or sub-regional office, upon the authorization of the manager of the regional office is authorized upon a determination of prima facie eligibility to provide:

1. Out-patient medical treatment at a Veterans Administration field station or on a fee basis from a certified fee-designated physician if conditions do not permit the veteran's treatment at a Veterans Administration facility.

2. Emergent hospitalization at a Veterans Administration field station or at a private or contract hospital if conditions do not permit the veteran's hospitalization at a Veterans Administration facility.

PRIMA FACIE ELIGIBILITY DEFINED

The circular states that the following factors shall be considered in determining "prima facie eligibility" for out-patient treatment or emergent hospitalization:

1. When application is made for medical treatment or hospitalization because of a chronic disease manifested within two years from the date of discharge from a period of war-time service of three months or more, there will be conceded prima facie evidence of eligibility unless the character of the condition or other evidence indicates it to be due to intercurrent disease or injury.

2. A request for out-patient treatment for other conditions within two years from date of discharge from service may be favorably considered upon a detailed statement of the claimant as to the nature of the injury or disease suffered in service and containing evidence warranting a tentative conclusion that the condition requiring treatment had its origin or aggravation in service.

3. In like manner, eligibility for out-patient or hospital treatment for emergent conditions not due to intercurrent disease or trauma may be determined without regard to any time period following discharge from service. However, such determination must be in accord with sound medical principles.

USE THE TELEPHONE!

In seeking authorization to examine or treat veterans, physicians will find it expedient to get in touch via telephone with the nearest Veterans Administration office.

This will enable the physician to provide information on the case and to obtain instructions promptly on the handling of the case.

This procedure should be followed regardless of whether the case is an emergency in which treatment already has been provided; whether the case is one in which the veteran has filed a claim which is being adjudicated; or whether the case is one in which the disability has been judged service-connected but where treatment, or additional treatments have not been authorized.

DETERMINING FACTORS

It is stated that "eligibility" may be generally defined as that evidence which is considered sufficient to justify the conclusion of the chief medical officer that the disability will in all probability be adjudicated as service-connected and that the character of the veteran's discharge permits such authorization.

Consideration will be given to the clinical course of the condition, its etiology, duration, and chronicity as reflecting relationship to service.

Tropical diseases, when the veteran has served in the tropics, avitaminosis, metabolic disturbances in prisoners of war, and gunshot wounds of combat veterans are typical illustrations of cases which require little additional evidence as to service relationship.

On the other hand, acute conditions without evidence of previous pathology, diseases having short periods of incubation, and conditions presented for surgical treatment of optional or purely corrective types without evidence of service injury will not be favorably considered.

MUST HAVE STRONG EVIDENCE

Conditions for which request for treatment is made more than 12 months from date of discharge, other than emergent conditions, must be adequately supported by evidence indicating serv-

ice responsibility since such conditions, with the exception of tuberculosis, are not regarded as of service-connection in the absence of evidence of the presence of the disease or injury in service or showing of continuity of the condition from date of discharge.

Out-patient treatment or hospitalization will not be continued on the authority of the chief medical officer unless an examination made coincident with or prior to the initial treatment sets forth clinical findings justifying the need for further treatment.

WHEN ELIGIBILITY CEASES

Once a determination of non-service-connection has been made by a pension rating board, eligibility for continued out-patient treatment ceases and subsequent rehospitalization in a private or contract hospital will be denied. Such ineligibility continues from the time the rating board renders a finding of non-service-connection until the veteran wins eligibility on appeal, if appeal is made.

A veteran whose claim has been disallowed and who subsequently files a supplemental claim for other disabilities ordinarily will not be permitted to receive out-patient treatment or hospitalization in a private or contract hospital pending the adjudication of the supplemental claim. However, exceptions may be made where the condition for which the subsequent treatment or hospitalization is sought did not manifest itself or was not discernible on examination prior to the denial of the original claim, or was not included in the data transmitted by the service department.

If the rating board finds that a veteran is ineligible to receive treatment for a service-connected disability, the chief medical officer is expected to immediately notify the fee-designated physician who has been treating him that the condition has been adjudicated as not service-connected and that the Veterans Administration will not pay for any further treatment for this condition.

If such veteran is being hospitalized in a private or contract hospital, he will be transferred to the nearest Veterans Administration hospital as soon as his condition permits and providing further hospitalization is necessary.

The Veterans Administration is liable for any out-patient treatment and emergent hospitalization previously authorized until notifications that his condition has been adjudicated as non-service-connected have been sent.

Dr. Judson D. Wilson, Columbus, has been named medical director of the crippled children's program of the Aladdin Temple of the Shrine. He succeeds the late Dr. William D. Murphy, one of the founders of the movement, and medical director from its organization in 1925 until his death last Spring.

COMING MEETINGS

Ohio State Medical Association, Cleveland, May 6-8, 1947.

American Medical Association, Atlantic City, June 9-13, 1947.

House of Delegates, American Medical Association, Semi-annual meeting, Chicago, Dec. 9-11.

Annual Conference of State Secretaries and Editors, Chicago, Dec. 7-8.

American Academy of Dermatology and Syphilology, Cleveland, Dec. 7-12.

American College of Physicians, Chicago, April 28-May 2, 1947.

American College of Surgeons, Cleveland, Dec. 16-20.

American Congress on Obstetrics and Gynecology, St. Louis, Sept. 8-12, 1947.

American Society of Anesthesiologists, New York, Dec. 12.

Annual Clinical Conference, Chicago Medical Society, Mar. 4-7, 1947.

National Congress on Rural Health, Chicago, Feb. 7-8, 1947.

National Conference on Medical Service, Chicago, Feb. 9, 1947.

National Congress on Medical Education, Chicago, Feb. 10-11, 1947.

V. A. Reports 29 Per Cent Increase in Hospital Admissions

There has been a 29 per cent increase since V-J day in the number of veteran-patients in its hospitals and homes and in other hospitals under contract, the Veterans Administration has announced. The total on Sept. 12 was 104,612 patients, compared with 81,081 on V-J day. The biggest increase occurred among World War II veterans with non-service-connected disabilities. The number of such patients rose from 10,338 to 24,437, an increase of 136 per cent.

The number of World War II veterans receiving medical care for service-connected disabilities increased from 11,593 to 17,476, a rise of 51 per cent.

Need Physical Medicine Specialists

Specialists in physical medicine are urgently needed by the Veterans Administration for assignment to hospitals, regional and sub-regional offices through the country, Dr. Paul R. Hawley, chief medical director, has announced. Applications should be submitted to a branch office or to the regional office or hospital where appointment is desired. Positions will be offered in the grades commensurate with the applicants' training and experience in the field of physical medicine.

In Our Opinion: Comments on Current Economic and Social Questions and Professional Problems; Suggestions Regarding Organized Activities

WHAT CAN BE DONE ABOUT THE PROBLEMS OF THE G.P.?

Much has been written regarding the need for restoration of the general practice of medicine and the general practitioner to the important position which they once held in the practice of medicine. Most physicians, as well as others, who have considered the question have agreed that something urgent must be done to correct what has become a serious problem. Many suggestions are being offered in Ohio and elsewhere.

Some exceedingly stimulating thoughts on this subject are found in a communication received by the Editor from Dr. George A. Woodhouse, Pleasant Hill, Ohio, a general practitioner, an Ohio delegate to the American Medical Association, secretary of his county medical society, a member of several important committees of the Ohio State Medical Association, and a delegate to the Ohio State Medical Association.

Because Dr. Woodhouse is in a position to speak with authority and from experience and is known by reputation to be one who is not swayed by emotions or personality factors, it is our opinion that his views should carry considerable weight and should be seriously considered. His letter on the subject follows:

"There is a very urgent cry coming from the wilderness! The voice crying loudly is that of the general practitioner of medicine. The wilderness is the absolute control of numerous hospital staffs by 'board' members; the apparent increase of various types of group medical practice; and the very evident decrease in number of the family type of doctor.

"This is an unusual paradox, since the general practitioners comprise some 80,000 of the total number of some 120,000 qualified doctors of medicine in the United States. If for no other reason than the force of numbers they should be able to control their own destiny. The general practitioner has maintained the hospitals, the various groups of medical specialists, and the coordinated groups in clinic practice by referring them patients and thus extending their prestige.

"However, after all these years in helping to build up these institutions and individuals, the general practitioner now finds himself without the gates of closed hospital staffs and surrounded by edicts of the groups which he has so well patronized.

"Every physician should be concerned with the problems which appear to be of such paramount importance not only to the general practitioner but to the future of free medical practice in the United States. Some of them are as follows:

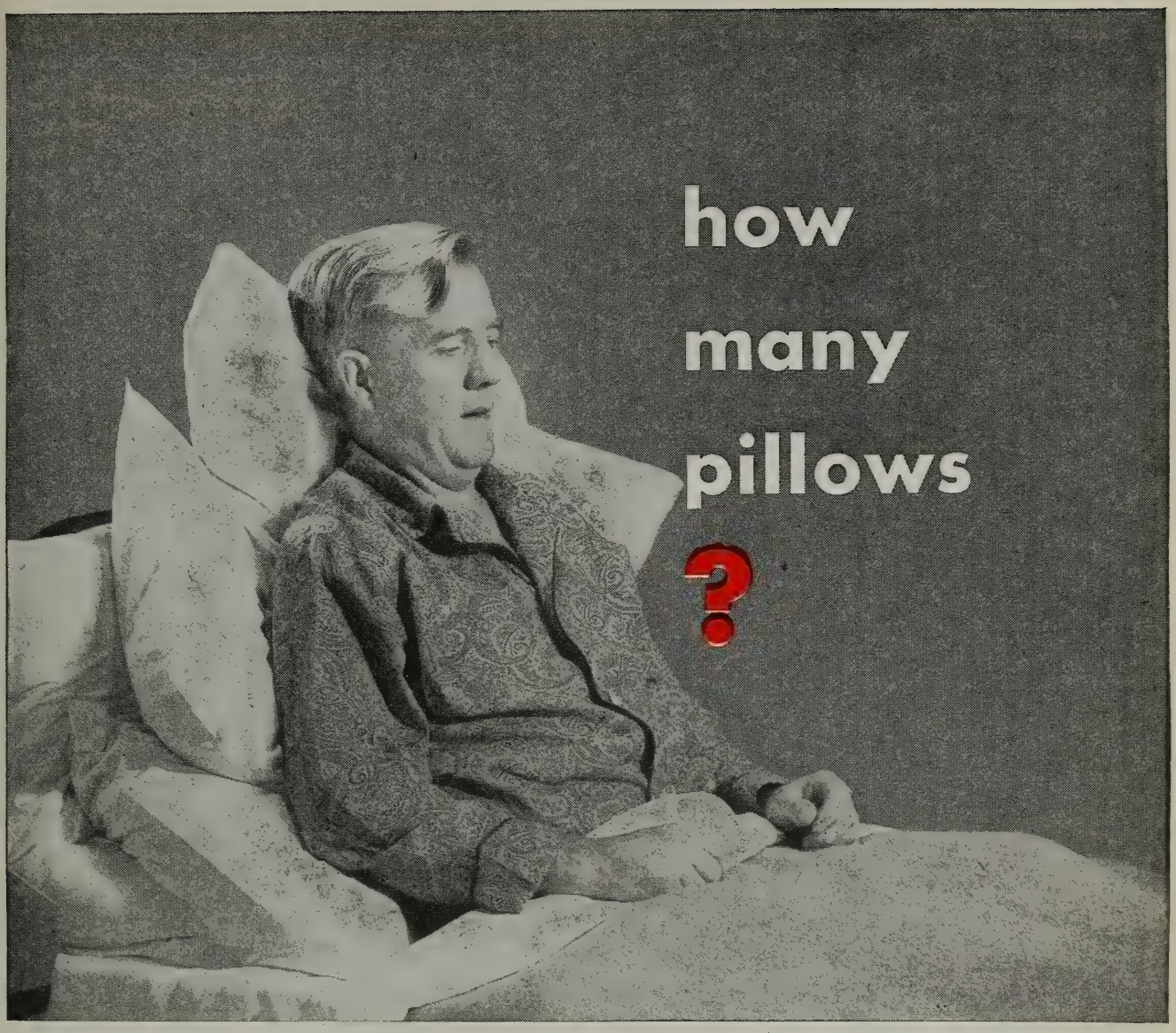
"(1) There is an urgent need for closer and more cooperative organization of the general practitioners in the county and state medical organizations. Within their various organizations the preponderance of numbers voting as a unit can force proper recognition of hospital staffs and can overcome many of the maladjusted practices of 'group practice'. This closely compacted organization can reincarnate into the minds of the public the proper high regard for the family physician, as the first line of medical service. These organized groups can by self assertion offset the apparent sole recognition of medical specialists by various governmental agencies. Proper outlet to their pronouncements can increase the distribution of medical care in regions now so devoid of medical practitioners. Cooperative assistance within these groups and their medical societies can increase the numbers of general practitioners in official offices in the recognized medical organizations.

"(2) What has been done to help solve this problem? The American Medical Association House of Delegates has been constantly spurred to establish a General Practitioners Section in the Association. This has finally been done and is now an accredited section of the annual Scientific Assembly. In addition, the last session of the American Medical Association House of Delegates (July, 1946) recommended that sections for general practitioners be set up in each state medical organization. This was done in Ohio in May, 1946. The matter of providing a General Practitioners Specialty Board has also received consideration at various times. In 1944, a resolution on this subject was presented to the A.M.A. This was subsequently reported on at the December, 1945, meeting of the House of Delegates, but due to delay by the sponsors in adopting specific recommendations, the subject was dropped from the agenda.

"(3) What can be done in the immediate future? It is suggested that through close cooperation of the regularly constituted General Practitioners Sections in the larger Academies of Medicine and County Medical Societies and the consideration of these problems in statewide group meetings of their officers, many of these apparent discrepancies could be analyzed and plans for correcting the errors could be worked out. The matter of a General Practitioners Specialty Board could be adequately discussed. This latter proposal is one that has many angles, favorable and otherwise. It would require much planning and discussion to establish its feasibility and to determine its possible effectiveness. The formulation of concrete objectives to be presented to the state and national general practitioners section could result from such meetings.

"It is also suggested that the various medical colleges could re-arrange to some extent their courses or could add certain types of work which would point out to the medical students the attractions offered and the inducements present in the general practice of medicine. Perhaps a period of service in general practice should be a required qualification in obtaining recognition by the specialty boards.

"The close cooperation of general practitioner



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RESEARCH IN THE SERVICE OF MEDICINE

groups with the newly organized Committees on Rural Medical Service of the Ohio State Medical Association and the A.M.A. would be of unusually great value in helping to solve some of the difficulties present.

"Many excellent articles have been written recently pointing out some of the problems of the general practitioner. Two of unsual interest appeared in recent editions of *The Journal of the American Medical Association*: 'The General Practitioner', June 8, 1946, and 'The Family Doctor', September 7, 1946. There is also a trend toward publishing more articles written by general practitioners. It would be beneficial if more general practitioners would devote more time to medical writing and to pointing out the need for a revival in the field of general practice.

"In order to have a free and unencumbered medical service and one adequate to meet the needs of the American people, the number of general practitioners must be increased and their services must be constantly expanded.

"It is also true that a certain lack of interest on the part of the general doctor is responsible for many of his now apparent problems. He has fallen into his present dilemma due to apathy on his own part. Now in order to extricate himself from the position in which he has been placed in many localities, he must arise, take over his drooping if not fallen banner, and again lead the medical profession, which by the preponderance of numbers he should most rightfully do."

'TWOULD BE A REAL RELIEF, FOLKS

An International News Service dispatch from Washington quotes Senator Robert A. Taft, Ohio, as stating that he may seek the chairmanship of the U.S. Senate Committee on Education and Labor in the next Congress in preference to the chairmanship of the Finance Committee.

If this materializes, it will be welcome news to members of the medical profession as many of the bills in which the profession is vitally concerned are usually assigned for hearing to the Committee on Education and Labor.

It is conceivable that Senator Taft and members of the medical profession might not be in agreement on all of the numerous health-welfare measures which will be presented to the Congress. Nevertheless, with Taft at the helm of the committee, both pros and cons will be assured of a fair hearing which will certainly be a relief from the high-handed and undercover tactics of the present committee chairman, Senator Murray of Montana.

BIG GOVERNMENT AND STATE RIGHTS

As a result of the turnover in personnel of the next United States Congress, the actions of Congress when it meets next January will be watched with critical interest by those who sense that the underlying issue relates to how much the Federal Government should do or how much should be left to the initiative of the individual state and local governments.

There is danger in big, centralized government. That has been demonstrated by the events of the past decade. On the other hand, more than mere lip-service to the plea for "state rights" will be required to meet certain domestic problems.

If "big government" at Washington is to be abandoned, added responsibilities must be assumed by the individual states in those fields in which government must play a part.

The job can be done by the states, in our opinion. Whether the job will be done remains to be seen. Unless the job is done by the states an even greater surge toward extreme centralization may be anticipated at a not too distant date. A real challenge confronts those who advocate decentralization and a return to state rights.

WHO IS GOING TO RUN A.P.H.A.? BUREAUS OR PEOPLE?

We see by the papers that Dr. Martha M. Eliot, associate chief of the United States Children's Bureau, has been named president-elect of the American Public Health Association.

Unquestionably, Dr. Eliot's personal and professional reputation are beyond suspicion. Nevertheless, there are many who don't like the tactics and methods which are the usual stock in trade of the agency for which she works.

The American Public Health Association has made many splendid contributions in the past. It can continue to do so providing it steers clear of political bureaucracy. Difficulties confront it if it plans to select leaders from among those who regard government regulation as the country's salvation. The record of the Children's Bureau is just that. We assume that Dr. Eliot's views coincide with those who dictate the policies of the agency. The hook-up is not good. If it was done with a purpose, we think less of the action taken at the Cleveland meeting.

CONTRIBUTING CAUSES OF MALPRACTICE CLAIMS

Young physicians entering active practice for the first time or those who may be a bit rusty on some of the factors involved in dealing with the public because of war-time service should heed the warning that they are constantly confronted by the potential suit for alleged malpractice.

The best answer to how to avoid such suits is found in an analysis of some of the causes of malpractice claims. One big cause is loose talk and criticism by one physician about another physician especially when he doesn't know all the facts in the case. In addition, there are



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a number of contributing causes. These have been well stated by Dr. Louis J. Regan, Los Angeles, in an article which appeared in the *California Medicine*. They are:

1. Failure of the physician to exercise tact in his contact with the patient and the patient's family.
2. Charging excessive fees.
3. The use of irritating fee collection methods.
4. Making over-optimistic prognoses, promising too much to the patient.
5. The failure to prepare the patient for reasonably to be anticipated anatomical, cosmetic, or functional defect or deficiency.
6. The delegation of duties to poorly qualified assistants beyond their capacity to perform.
7. The physician absenting himself without notice to his patients, and without arranging to have a well qualified substitute available.
8. The failure to have a consultant see a patient who is complaining of his care or progress.
9. The making of statements which can be construed as admissions of fault.
10. The physician telling the patient that he has malpractice insurance coverage.
11. The failure to warn the patient against his unwise course when he does not follow advice, or discontinues treatment before he should.
12. The undertaking to treat cases not well within the physician's experience and understanding.
13. Failure to secure consent to operation and for autopsy.
14. Failure of the physician to keep abreast of developments in his profession.
15. Utilization of procedures of an experimental character.
16. Failure to employ X-ray and clinical laboratory facilities in diagnosis and in treatment.
17. Failure to exercise ordinary care in maintaining plant and equipment in a safe condition.
18. Abandonment of the patient.

GOOD ETHICS MEAN GOOD PUBLIC RELATIONS

Good public relations has been defined as "first doing right by the people—and then telling them about it". Newspaper or radio publicity lauding the medical profession and its accomplishments sounds good to satisfied patients, but it doesn't get very far with persons who feel that a physician has done badly by them, either through poor treatment or exorbitant charges. Fortunately, these in the latter group are relatively small, but they can be quite vocal.

Every doctor in his daily practice can be a purveyor of good public relations. All he need do is to follow Section 1, Chapter 1, of the Principles of Medical Ethics of the American Medical Association. Entitled "The Physician's Responsibility", the section reads as follows:

"A profession has for its prime object the service it can render to humanity; reward or financial gain should be a subordinate consideration. The practice of medicine is a profession. In choosing this profession an individual assumes an obligation to conduct himself in accord with its ideals."

YOU CAN'T AFFORD TO BE THIS BUSY

Detection clinics and routine periodic physical examinations were advocated by speakers before a section of the American Public Health Association during its recent session in Cleveland as important factors in present-day cancer control programs.

According to Josephine Robertson of the *Cleveland Plain Dealer* staff, following these talks certain members of the audience "suggested that a first step in a cancer control program was to educate the medical profession 'to adopt a sensible attitude towards persons over 35 who come in for routine physical examinations even though they have no symptoms and not to refuse them examinations on the ground that they are neurotic.'"

Here again we have a criticism which is justifiable in the case of too many physicians and which weakens the public relations of the medical profession, in addition to depriving too many persons of services which they should have.

In this day and age, no physician can afford to be too busy taking care of persons who know they are sick to refuse preventive services to those who want to remain well.

WHAT ARE YOUR VIEWS AND SUGGESTIONS?

The following quotation appeared in a recent issue of the *Connecticut State Medical Journal* over the signature of the President of that society.

When you read it substitute the word "Ohio" for the word "Connecticut" and then form your own opinion. Communications on this question which members of the Ohio State Medical Association may care to offer will, we are sure, be given careful consideration by The Council of the Association. Send them to us and we'll see that they get to the proper officials. Said the Connecticut prexy:

"Just what are we getting out of our membership in the County Medical Associations? What benefit do we derive from our membership in the State Medical Society?

"Do some of us feel that precedent and prestige demand that we belong to the 'union' and that by paying our dues our obligations are fulfilled? Having met this heavy duty, do we hold ourselves aloof, believing that a self-perpetuating group controls the affairs of the So-

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ciety? Are some of us so self-sufficient that we are in no need of the mutual benefits that such a society can provide?

"It should be clear that the Society belongs to the individual member. It is his instrument of contact with his fellow physicians. It is his sounding board if he so desires. It can be a source of information and it can be a constant inspiration.

"On the other hand, it can be a dreary, impotent, disorganized hodgepodge. The Society can be and will be just what its individual members make it by their action and interest—or by their apathy and indolence.

"There are some who feel a duty that can not be paid in dues. They willingly sacrifice time, money, and family interests in furtherance of the profession they love. These men are all too few, and the good of the Society requires many, many more.

"Ask yourself this question: If the Connecticut State Medical Society is not giving you the things you think it should; if it is not progressive according to your views; if it is not meeting a profound need of the medical profession; what have you done about it, or what do you intend to do, besides paying your dues? Your ideas and your criticisms for the improvement of the quality of service are needed—but they will be of little value if you remain silent."

A SUGGESTION TO THE GOVERNOR-ELECT

According to a letter issued by a group of physicians prior to the election on November 5, supporting the candidacy of Governor-elect Thomas J. Herbert, Mr. Herbert read and endorsed each of the planks of the 25-point Health Program for Ohio, adopted by the House of Delegates of the Ohio State Medical Association last May.

The medical profession of Ohio should be pleased to learn that Mr. Herbert was favorably impressed with the Association's recommendations. We trust that the new Governor will use his efforts to see that the State of Ohio meets those responsibilities which the Association's program outlines as the definite responsibilities of the state. This would add impetus to the program. Ohio can have a real health program if all groups in Ohio, including the State Government, will do their part. Governor-elect Herbert apparently is in agreement. We hope that he will show us a good follow-through.

It might be advisable for the new Governor to take a look-see at the present situation in the State Department of Health. The department under the able direction of Dr. Roger E. Heering is operating efficiently. But there is more to the story than just that. It is too dependent upon the Federal Government for resources and personnel.

Figures from the Ohio Department of Health records show that the State of Ohio is putting up about $526,000.00 annually during the present biennium for departmental activities and for subsidies to local health units, required by law.

During the present Federal fiscal year, which began July 1, 1946, the health department will receive about $1,500,000.00 from the Federal Government for such important activities as general public health work, venereal disease and tuberculosis control, industrial hygiene programs, and maternal and child health activities. This sum does not include funds received from Washington for the E.M.I.C. program for the families of service men.

Of the 228 positions in the department now filled, 136 employees are paid out of Federal funds; 92 out of state funds. Federal money amounting to about $495,000.00 is used for salaries and travel expenses and an additional amount of $162,556.00 is used for miscellaneous operating expenses. The total of these items alone, which excludes salaries and expenses of Federal personnel "loaned" to local health units, is almost $200,000.00 more than the total amount of money supplied by the State of Ohio for essential and basic operations.

Four of the division heads of the health department are paid from funds received from the Federal Government and two more division chiefs are "on loan" from the U. S. Public Health Service. Five division heads are paid from Ohio money.

Dr. Heering has termed this "a seriously unstable state of affairs". That is putting it mildly. Ohio, which has allegedly fought centralization of power in Washington and has cried bloody murder about government by New Deal bureaucrats, should be ashamed of this record. Assuming that all of the activities being carried on by the Ohio Department of Health are essential —we believe with perhaps a few minor exceptions, they are—Ohio should either put up or shut up. The wise course to follow would be the former.

Governor-elect Herbert would do well to see what can be done about putting Ohio on its own feet on matters relating to public health. Under present conditions the control of far too many public health activities in Ohio rests, in the final analysis, with the powers in Washington. If Ohio doesn't like that, now is the time to put an end to it. But, the job can't be done on a bread-and-water budget.

TIP TO EX-MEDICAL OFFICERS ABOUT BOARD DATA

Physicians who were in the services during World War II and who are contemplating applying for a certificate of a specialty board at some future time should start right now to assemble data which will prove valuable in qualifying for board examinations.

Since all specialty boards allow credit for time and work in the armed forces, the ex-medical officer who intends to try to qualify in the fu-

SUBJECT: "YOUR DOCTOR"
AUDIENCE: 23 MILLION PEOPLE

This is the 200th message published by Parke, Davis & Company in the interest of the medical profession. It appears this month in full color in LIFE and other leading national magazines.

Some things you should know about your doctor

No. 200 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.



IN TIMES of distress, almost everyone turns to his doctor. But when things are going smoothly, some people are apt to take him pretty much for granted.

However, if you consider your doctor's service to you and to the country—if you consider the skills he must have, the sacrifices he must make, the hardships he must work under—then it isn't very easy to take him for granted.

To become a doctor usually requires three to four years of pre-medical education, four years of medical school, and another year or more as an interne. But this by no means represents the end of his training.

Do you realize how much time your doctor has to spend in *continuing* study—so he can bring you the benefits of all the latest medical advances?

During a year the average American doctor devotes the equivalent of about a month to the study of medical books and journals and to attending medical meetings.

It's an old story about how many patients a doctor has to see every day, how much of his time he devotes to charity, how many calls he has to make in the middle of the night. But did you ever think of it this way:

When you leave your office or job, the chances are that you're free from business duties for another day. You can do whatever you feel like—you can dig in your garden, visit friends, have a quiet evening at home with your family, drop in at a movie, or go for a drive. But your doctor's work is never finished. He's always—every waking and sleeping moment—responsible for the patients under his care.

Yes, it takes a lot of things to be a good doctor. It takes physical and nervous stamina. It takes patience. It takes great tact. It takes an understanding of people. It takes sound judgment. It takes unusual scientific and scholastic aptitude. It takes a sympathy for the unfortunate. Above all, it takes a spirit of humanitarianism and a sense of service.

Tall order, isn't it? Yet thousands and thousands of American physicians have all these qualities—and more. They are outstanding men and women. America should never cease to be proud of them.

Makers of medicines prescribed by physicians

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ture should start collecting and putting down data arising from his service duties. Some of this has to be supplied by the physician himself from memory. Some has to be obtained from War or Navy department records. Certain documents must be signed by former commanding officers. For these reasons, the time element is important.

A booklet in which assignments and professional duties can be recorded, for immediate or future use, may be obtained from the American Medical Association or the secretary of any of the specialty boards. Completion of this booklet will give the ex-medical officer a fairly complete record for submission to a board at any time.

ARE YOU A FELLOW OF THE A.M.A.? BETTER SIGN UP

The American Medical Association is going to celebrate its centennial in Atlantic City, June 9-13, 1947. Elaborate plans are being made for this celebration.

Only Fellows and invited guests are eligible to attend. Membership in your state society is the primary qualification for Fellowship in the A.M.A. Fellowship dues and subscription to *The Journal of the A.M.A.* are both included in one annual payment of $8.00, which is the cost of *The Journal* to subscribers who are not Fellows.

If you are not a Fellow and plan to attend the Atlantic City session, which will be a milestone in medical history, you can save yourself considerable time and confusion when registering, if you will write now to the American Medical Association, 535 North Dearborn Street, Chicago 10, and ask if you are eligible to become a Fellow.

Outstanding Programs for 1946-1947 Arranged by Cincinnati Academy

The Academy of Medicine of Cincinnati has arranged an outstanding scientific program for the year 1946-1947. All interested physicians are invited to attend these meetings, which usually are held in the Academy Auditorium, Sixth Floor, Union Central Annex Building, Cincinnati. The meetings begin at about 8:30 p.m.

Thus far the Academy has heard Thomas A. Hendricks, secretary, Council on Medical Service and Public Relations, American Medical Association, speaking October 1 on medical economics, and Elliott P. Joslin, clinical professor of medicine, emeritus, Harvard Medical School, who discussed diabetes at the October 15 session.

Bayard T. Horton, M.D., associate professor of medicine, the Mayo Clinic, Rochester, Minnesota, spoke on the subject, "Headache—Diagnosis and Treatment", at the November 12 session. On November 26, Edward B. Tuohy, M.D., professor of anesthesiology, also from the Mayo Clinic, discussed "Anesthesiology—Practical Considerations and Current Prospectus". This was a joint meeting with the Cincinnati Society of Anesthesiology.

The program for the remainder of the year is as follows:

Dec. 3—Franz G. Alexander, M.D., director of the Chicago Institute for Psychoanalysis, Chicago, "The Psychosomatic Approach of the Disturbances of the Vegetative Functions".

Dec. 17—Richard B. Capps, M.D., assistant professor of medicine, Northwestern University Medical School, Chicago, "Infectious Hepatitis".

Jan. 7—Reginald H. Smithwick, M.D., associate of the Massachusetts Memorial Hospital, Boston, "The Surgical Treatment of Hypertension".

Jan. 21—Edgar Allen, M.D., associate professor of medicine, the Mayo Clinic, Rochester, Minnesota, "The Present Status of Anticoagulant Therapy".

Feb. 4—Herbert F. Traut, M.D., professor of obstetrics and gynecology, University of California School of Medicine, San Francisco, "The Present Status of Hormone Therapy in Gynecology".

Feb. 18-19—Alfred Blalock, M.D., professor of surgery, Johns Hopkins University School of Medicine, Baltimore, and Helen B. Taussig, M.D., associate professor of pediatrics, Johns Hopkins University School of Medicine, "Diagnosis, Surgical Treatment and Results in Congenital Heart Disease".

(The B. K. Rachford Lectures.)

Mar. 4—Cecil J. Watson, M.D., professor of medicine, University of Minnesota Medical School, Minneapolis, "Certain Aspects of the Problems of Hepatitis and Cirrhosis".

(The Roger Morris Lecture.)

Mar. 18—Irvine H. Page, M.D., associate of the Cleveland Clinic, "The Medical Treatment of Hypertension".

(Joint Meeting with the Heart Council.)

Apr. 1—Walter Bauer, M.D., associate professor of medicine, Harvard Medical School, Boston, "Arthritis".

Apr. 15—Carl Binger, M.D., assistant professor of clinical medicine, Cornell University Medical College, New York City, "Psychiatry for the Millions".

May 6—Howard A. Rusk, M.D., consultant to the Veterans Administration and special correspondent for the New York Times, New York City, "Rehabilitation—The Third Phase of Medical Care".

May 20—Wesley W. Spink, M.D., associate professor of internal medicine, University of Minnesota Medical School, Minneapolis, "Diagnosis and Treatment of Brucellosis".

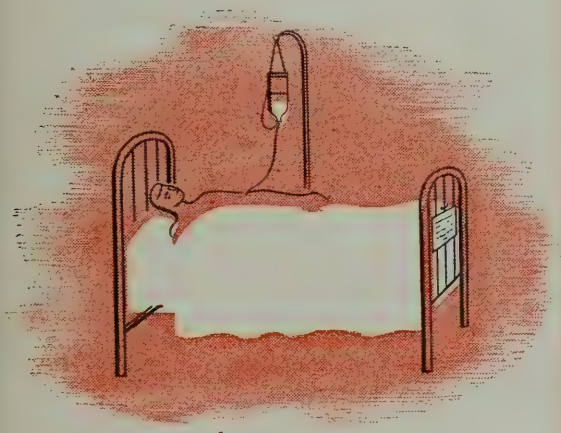
PREOPERATIVE

PREPARATION

"...the protein deficient individual is a poor operative risk."
Lund and Levenson: J.A.M.A. 128:95, 1945

"When time is available to improve protein nutrition before surgery and when this time is used efficiently for this purpose, the reduction in postoperative shock and other complications is impressive."

Editorial: Surg., Gynec. & Obst. 83:259, 1946



POSTOPERATIVE

REPARATION

"...the patient maintained in positive nitrogen balance recovers from major surgery more rapidly than does the patient who is not in nitrogen equilibrium."

Koop: Geriatrics 1:269, 1946

Parenamine

Parenteral Amino Acids

FOR PROTEIN DEFICIENCY

Preparative: To improve and protect the nutritional status of the severely malnourished or critically ill patient . . . as fortification against the shock of major surgery.

Reparative: To provide, in ample quantity, the amino acids essential to tissue repair . . . to hasten healing and shorten convalescence.

Parenamine is a 15 per cent sterile solution of all the amino acids known to be essential for humans . . . derived by acid hydrolysis from casein and fortified with *dl*-tryptophane.

For use whenever dietary measures are inadequate for correction and maintenance of positive nitrogen balance . . . to replenish depleted body protein stores. *Particularly indicated* in pre- and postoperative management, extensive burns, gastro-intestinal obstruction, etc.

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VETERANS' INQUIRY DEPARTMENT

Ohio Openings and Locations Sought by Returning Medical Officers; Opportunities Available Listed

THE purpose of this department is to provide space without cost to Ohio veteran physicians for the publication of inquiries they may wish to make concerning an assistantship or residency, a partnership or space in an office, locations and purchase of a practice, purchase of equipment, etc.

The new feature also offers an opportunity for physicians who desire to dispose of their practice or institutions and agencies needing staff physicians to publicize this information for the benefit of service men.

The feature will appear monthly as long as there seems to be a need for it. The regulations governing it are: (1) The veteran submitting the inquiry must be an Ohio physician, i.e., one who was in practice in Ohio when he entered the service or was a native of Ohio but still in training when he entered in the service. (2) Inquiries should not exceed 35 words. (3) Copy must be submitted by the 20th day of the month preceding date of publication. (4) Unless otherwise specified, each inquiry will be carried in two consecutive issues of *The Journal* but no oftener. (5) *The Journal* reserves the right to reject or edit copy submitted; also, to eliminate the new department when and if conditions warrant. (6) Inquiries should be accompanied by full name, forwarding address and identifying data.

The Veterans' Inquiry Department will be discontinued after the December issue, as few requests for insertions are now being received. However, the Headquarters Office at Columbus will continue to assist returning veterans in finding locations upon receipt of requests for information and assistance. Physicians knowing of locations or positions should file this information with the Columbus office.

OPPORTUNITIES SOUGHT

LOCUM TENENS DESIRED: Wanted for three months beginning September 15 by Navy medical officer who will begin residency January 1. Graduate of Harvard Medical School in 1944; aged 26; internship Lakeside Hospital, Cleveland. V.I.D. No. 22.

SEEKS INDUSTRIAL ARRANGEMENT: Veteran with extensive industrial background seeks association with individual or group in this type of practice. Willing to invest. Cleveland area preferred but others also considered. V. I. D. No. 23, care of Ohio State Medical Journal.

ASSOCIATION DESIRED: Veteran desires position with small medical group or assistantship with pediatrician or general practitioner in town over 20,000. Ultimate desire is to specialize in pediatrics. V.I.D. No. 26.

ASSISTANTSHIP WANTED: Surgeon, aged 32, Army experience and eligible to American Board of Surgery, available in Fall of 1946, desires assistantship to older surgeon, group practice, association with internist, etc. Experience in general surgery, neurosurgery, orthopedic surgery; Ohio license. V.I.D. No. 27.

WANTS ASSOCIATION WITH GROUP OR SPECIALIST: Army veteran, aged 31, married. Ohio State University graduate, Ohio license, eligible to American boards in obstetrics and gynecology, desires position with group clinic or established specialist. Spent 21 months in ETO in general surgery and ob-gyn. V.I.D. No. 29.

SEEKING ASSISTANTSHIP: Army veteran desires assistantship with general practitioner, with possible future partnership. Ohio State University graduate in 1943; rotating internship; aged 30; single. V.I.D. No. 30.

ASSOCIATESHIP, GROUP OR SPECIALIST SOUGHT: Veteran with qualifications for certification by American Board of Internal Medicine, aged 30, graduate of Ohio State University, desires association with group or with board member—preferably with university affiliations. Have had research and teaching experience. V.I.D. No. 31.

ASSOCIATION SOUGHT: Internist, completing three-year residency in internal medicine, January 1, 1947, interested in association with surgeon, with group or in part-time industrial practice. City of 15,000 or more population desired. V.I.D. No. 33.

LOCUM TENENS: Navy veteran wishes locum tenens or assistantship to general practitioner in Columbus or near vicinity until January 1, 1947. Have residency in medicine starting that date. Graduate, Ohio State University College of Medicine; internship at Los Angeles County General Hospital. V.I.D. No. 34.

ASSISTANTSHIP REQUESTED: Veteran, aged 35, Ohio license in 1935, desires assistantship with proctologist, starting July 1, 1947. Rotating internship, six years general practice, two years proctology in Army hospital, completing 18 months surgery residency. V.I.D. No. 35.

ASSISTANTSHIP OR PRACTICE DESIRED: Young, recently-discharged medical officer wants assistantship, partnership or established general practice in Northern or Central Ohio. Graduate of Ohio State University. Internship and 9-months residency in internal medicine completed. V.I.D. No. 36.

WANTS EVENING MEDICAL WORK: Veteran desires evening medical work, preferably in Cleveland area, doing routine physical examinations for industrial organization or insurance company. V.I.D. No. 37.

OPPORTUNITIES OFFERED

ASSISTANT WANTED: For busy general practice in small town, Northwestern Ohio. Duties to consist of general office practice, house calls, obstetrics and surgery. Starting salary $400 and car expenses. Percentage basis after first year. Give particulars in first letter. R.T.S., care of Ohio State Medical Journal.

ASSOCIATION WITH SURGEONS: Opening for young man, not interested in surgery, who would like to be associated in practice with two well-established surgeons. Compensation on percentage of gross income to the practice, depending upon training and personal qualifications. Part-time residence could be obtained in a small general hospital at substantial salary while a practice is being built. Industrial town of 15,000 population, Northeastern Ohio. All equipment and supplies furnished. Write H.R.A., care of Ohio State Medical Journal.

(Continued on page 1292)

RELIEF...

so long with so little!



Privine, one of the most widely prescribed vasoconstrictors, acts in a rapid manner to give prolonged relief. In nasal congestion of allergic or inflammatory origin as well as in acute and chronic rhinitis and rhinosinusitis, comfort for the patient is readily found by the rule of three—three drops three times daily... relief so long with so little.

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OPENING FOR ANESTHETIST: Diplomate of Board of Anesthesiology or fellow of American Society of Anesthesiology wanted as an associate or to practice independently as a full-time anesthetist. Write Fred W. Brosius, M.D., Middletown, Ohio.

PRACTICE AVAILABLE: General practice in DeGraff available. No property to sell. Forced to retire because of health. Good field for lively young physician. Write O. W. Loffer, M.D., DeGraff.

INTERNS AND HOUSEMEN NEEDED: Good Samaritan Hospital, Dayton, has openings for six interns. Internships approved by American Medical Association. Weekly seminars offered by members of various specialty boards. Also vacancies for four returning veterans as housemen; also entitled to seminars. Stipends for interns $50.00 with full maintenance; stipends for housemen, $150.00 with full maintenance. Contact Intern Committee of hospital.

ASSISTANTSHIP TO G.P.: Assistantship to busy general practitioner in large Northwestern Ohio city available; modern office. Percentage basis should average at least $5,000-$6,000 first year; partnership possible, later. Box Z, care of Ohio State Medical Journal.

LOCATION FOR GENERAL PRACTICE: Opening for general practice in town of 3,500 on Ohio River. Office space available. Shortage of active physicians at present. Box S, care of Ohio State Medical Journal.

INDUSTRIAL COMMISSION: Openings available in Medical Section, Ohio Industrial Commission. Consult Dr. Robert André, chief supervisor, Medical Section, State Office Bldg., Columbus.

STATE HOSPITAL STAFF OPENINGS: Staff physicians for various institutions serving the mentally ill, mentally defective and epileptic needed. Physicians who have had some psychiatric training or experience preferred but can offer positions to doctors who may be interested in becoming acquainted with the specialty. A position of special importance now open is: Clinical Directorship, Gallipolis State Institute (fine opportunity for man who has had neuropsychiatric training to become acquainted with those neurological conditions that cause epilepsy in addition to a chance to be a specialist in the field of true epilepsy). Consult Dr. Frank F. Tallman, Ohio Commissioner of Mental Hygiene, State Departments Building, Columbus 15.

PUBLIC HEALTH OFFICERS NEEDED: Several counties in Ohio in need of full-time health commissioners. Those with training and experience, or interested in public health work, may obtain complete details from Dr. Roger Heering, Ohio Director of Health, State Departments Building, Columbus 15.

PRACTICE FOR SALE: Active practice in a community of 3,000, North Central Ohio. Large amount of industrial work in addition to regular practice. Equipment includes new X-ray, diathermy, modern furniture, drugs and supplies. No real estate for sale. Moderate rent. Estimated price $7,500, cash or terms. Will introduce for a short time. Write R.J.S., care of Ohio State Medical Journal.

VETERANS ADMINISTRATION: Openings for physicians as members of rating boards for either full time or part time duty. Basic salary $4300.00 per annum, with additional compensation for overtime. Contact nearest V.A. office for particulars.

FULL-TIME RESIDENT PHYSICIAN NEEDED: At Homeplace, Perry County, Kentucky, operated by E. O. Robinson Mountain Fund as educational center for mountain people. Graduate nurse; clinic building being planned; affiliation with medical center in Cincinnati for consultation and specialized services; salary $5,000 per year, with home and transportation furnished. Write Dr. Howard P. Fischbach, 1122 Carew Tower, Cincinnati 2, Ohio.

PRACTICE AND HOME FOR SALE: Active practice established 10 years in town of 2000 with local post office serving 8000. Brick and stone home with modern interior. Has suite of rooms for office. All modern office equipment with stock of drugs and X-ray, diathermy, ultraviolet. Seeing more than 20 patients per day. Physician urgently needed. Forced by service-connected disability to retire from general practice. All is offered to a veteran for price of real estate alone. Liberal terms; can pay for all in three years from earnings. M. R. Wedemeyer, M.D., Oak Hill, Ohio.

HOSPITAL OPENING: Summit County Receiving Hospital, recently opened by welfare department, in need of assistant physician psychiatrist to do work of physician on military leave. Man under 35 years of age with residency in psychiatry preferred. Pay, $275.00 per month in addition to maintenance for self and family. Hospital also needs graduate nurses to complete staff, pay scale $163.00 for general floor duty to $196.00 for supervisory duty and Instructor, R. N. and a Director of Nurses, R. N. with baccalaureate degree. Write Summit County Receiving Hospital, Cuyahoga Falls, Ohio.

New Plan for Registering Fellows at 1947 A.M.A. Session

At the suggestion and under the direction of the Board of Trustees, a plan is being developed for advance registration of Fellows who will attend the Ninety-Seventh Annual Session of the American Medical Association in Atlantic City, June 9-13, 1947.

Arrangements have been made with the Housing Committee in Atlantic City to supply the headquarters office with duplicate slips of hotel room confirmations. These will be taken as evidence of proposed attendance. The A.M.A. office will send a letter and advance registration blank to Fellows who have made their hotel reservations. The registration form will be serially numbered, and this number will tally with that on an identification card that will be mailed to Fellows in return for the filled-in advance registration. The identification card is to be preserved and brought to the meeting.

The identification card when presented at the proper window of the Registration Bureau in the Atlantic City convention hall will enable the clerk to supply, in a matter of seconds, the official Fellow's badge of admission to the scientific and social functions, program and lapel buttons for guest or guests.

Any Fellow or Member planning to attend the meeting, but who will not have or need a hotel room in Atlantic City, should write also to the American Medical Association, 535 North Dearborn Street, Chicago 10, for an advance registration blank.

Trumbull County Society Postgraduate Session Attended by 200

The "First Post-War Postgraduate Day" sponsored by the Trumbull County Medical Society at the Armory in Warren, November 20, and featuring a group from the Lahey Clinic of Boston, drew an attendance of 200 physicians from the Northeastern part of the state.

The program began at 2 p. m. with a paper on "Treatment of Cardiac Emergency" by Dr. Lewis M. Hurxthal; Dr. Everett D. Kiefer followed with a discussion of "Functional Indigestion", and the third speaker was Dr. Richard B. Cattell, who spoke on "Carcinoma of the Colon and Rectum".

The next session began at 3:45 p. m. with a discussion of "Medical Aspect of Thyroid Disease" by Dr. Hurxthal followed by "Causes and Treatment of Diarrhea", Dr. Kiefer, and "Surgical Treatment of Goitre", Dr. Cattell.

After a turkey dinner, the program began again at 7:30 p. m. with "Diagnosis of Endocrine Diseases", Dr. Hurxthal; "Peptic Ulcer", Dr. Kiefer; and "Surgery of Stomach and Duodenum", Dr. Cattell.

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'Prothricin' Antibiotic Nasal Decongestant combines tyrothricin (0.02%) with 'Propadrine' hydrochloride* (1.5%) for the specific purpose of re-establishing normal drainage and combatting bacterial infection in the local treatment of sinusitis, rhinitis, coryza and nasal congestion.

Tyrothricin has a number of advantages over penicillin and the sulfonamides as a local antibiotic. The antibacterial range of tyrothricin is essentially the same as that of the sulfonamides, but tyrothricin when applied locally does not produce toxic effects, sensitize the patient, or produce a precipitate on the ciliated mucosa which may block drainage and impair normal function.

Applied locally, tyrothricin promptly attacks bacteria, and its low surface tension promotes penetration of tissue crevices and mucosal folds. Penicillin, unlike tyrothricin, is rapidly absorbed and removed from the site of application.

In addition to the antibacterial action of tyrothricin, 'Prothricin' decongestant contributes to normal drainage and re-establishment of mucosal function by means of 'Propadrine' hydrochloride, an effective vasoconstrictor notably free from the unpleasant side-effects of ephedrine and its analogs.

'Prothricin' Antibiotic Nasal Decongestant is supplied in 1-ounce, dropper-assembly bottles bearing no expiration date, for this solution is stable, and indefinitely retains full antibacterial-vasoconstrictor potency at ordinary room temperature.

Sharp & Dohme, Philadelphia 1, Pa.

*Council-Accepted

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'PROTHRICIN'

antibiotic nasal decongestant

RETURN TO CIVILIAN LIFE

The listing of physicians being released from military service will be discontinued after the December isssue. However, those being released should send this information and their new address to The Journal. This data will be used to correct mailing lists; to keep card records up to date; and for news items in The Journal.

FOLLOWING are the names of additional Ohio physicians who have been released from military service or have started terminal leave, according to information received recently by *The Journal.* The rank shown is based on the most recent data in the files of the Ohio State Medical Association.

Name	City	Rank
Ahlering, William C.	Brookline, Mass. (formerly of Cincinnati)	Lt., U.S.N.R.
Belinky, Nathan D.	Youngstown	Major, A.U.S.
Berger, Benjamin	Cleveland	Capt., A.U.S.
Boehmer, Henry E.	Cleveland	Capt., A.U.S.
Cahill, Robert C.	Marion (formerly of Columbus)	1st Lt., A.U.S.
Carney, Wilfred I.	Fall River, Mass. (formerly of Youngstown)	Lt. Col., A.U.S.
Cofield, Robert	Felicity (formerly of Cincinnati)	Lt. (j.g.), U.S.N.R.
Cooper, Jack R.	Columbus	Capt., A.U.S.
DePiero, Nicholas	East Cleveland	Capt., A.U.S.
Eddy, Howard C.	Mercer Island, Wash. (formerly of Cleveland)	Col., A.U.S.
Ensign, William G.	Cleveland	Capt., A.U.S.
Fintz, Ralph J.	Cleveland	Capt., A.U.S.
Frankel, David E.	Cincinnati	Lt. Col., A.U.S.
Gelbman, Frank	Albany, New York (formerly of Youngstown)	Major, A.U.S.
Green, Joseph	Van Nuys, California (formerly of Cincinnati)	Major, A.U.S.
Heller, Glenn H.	Coral Gables, Florida (formerly of Akron)	Major, A.U.S.
Heppl, John A.	Cleveland	Capt., A.U.S.
Hill, Scott	Canton	Major, A.U.S.
Hilsinger, Raymond L.	Cincinnati	Lt., U.S.N.R.
Hines, Robert B.	Uhrichsville (formerly of Barnesville)	Capt., A.U.S.
Hulit, Bob E.	Akron	Lt. (j.g.), U.S.N.R.
Klewer, Harold W.	Toledo	Lt. Comdr., U.S.N.R.
Kupec, Joseph B.	Youngstown	Capt., A.U.S.
LaFollette, Paul S.	Coshocton (formerly of Canton)	Lt., U.S.N.R.
Lieser, William A.	Canton	Major, A.U.S.
Linn, Robert F.	Lakewood	Capt., A.U.S.
Nickerson, John R.	Heron Lake, Minn. (formerly of Akron)	P.A.S., U.S.P.H.S.
Novello, A. J.	Lorain (formerly of Ashtabula)	P.A.S., U.S.P.H.S.
Pocock, Herman D., Jr.	Cleveland	Lt., U.S.N.R.
Richards, Edwin D.	Lakewood	Lt. Comdr., U.S.N.R.
Rosenberg, Norman J.	Cleveland	1st Lt., A.U.S.
Rothe, William S.	Columbus (formerly of Toledo)	Capt., A.U.S.
Schilke, Elliott W.	Springfield	Capt., A.U.S.
Schuster, George	Toledo	Lt., U.S.N.R.
Shorten, Edward A.	Youngstown	Lt., U.S.N.R.
Sternfeld, Ernst	Toledo	Capt., A.U.S.
Stilwill, M. E.	Canton (formerly of Massillon)	Capt., A.U.S.
Strauch, James H.	Cleveland	Lt. (j.g.), U.S.N.R.
Urban, Frank K.	Dayton (formerly of Cleveland)	Capt., A.U.S.
Weinman, Edward B.	Steubenville	Major, A.U.S.
Wharton, Joseph E.	New Orleans, La. (formerly of Athens)	Capt., A.U.S.
Wickter, Ralph A.	Toledo	Capt., A.U.S.
Wilkerson, Joseph L.	Toledo	Lt. (j.g.), U.S.N.R.
Williams, Lester L.	Colorado Springs, Colo. (formerly of Mt. Vernon)	Capt., A.U.S.

Ohio Department of Public Welfare Announces Four Appointments

Four appointments within the Ohio Department of Public Welfare were announced during November, three of them being in the Division of Mental Hygiene, and the other in the Division of Social Administration.

Dr. Mark W. Garry, former director of the Tuberculosis Division of the Ohio Department of Health, was appointed to the position of chief of tuberculosis and internal medicine of the Division of Mental Hygiene. He is in charge of tuberculosis control and treatment in the institutions and also will be responsible for organizing the medical program of the institutions of the Division. Dr. Garry is a graduate of the School of Medicine, Marquette University. He became affiliated with the Ohio Department of Health in 1945.

Miss Anna T. Lownie, B.S., M.A., R.N., has been named chief of nursing service and education for the Mental Hygiene division. Miss Lownie is a graduate of St. Elizabeth's Hospital in Boston, and just prior to her appointment here, was director of nursing and director of the Postgraduate School of Psychiatric Nursing at Menninger Sanatarium, Topeka, Kansas. Miss Lownie is responsible for nursing service of patients and the nursing education program of the Division.

Wallace C. Fotheringham, B.A., M.A., who has been named chief of institutional personnel training for the same Division was a professor at Muskingum College. His major responsibility is the organization of training courses for psychiatric aides in the institutions of the division. Cambridge State Hospital has served as a laboratory for the in-service training of psychiatric aides, and the methods and materials developed there will be utilized in other institutions.

Dr. Elizabeth Bryan was named medical director of Crippled Children's Services, under the Division of Social Administration. A graduate of the Western Reserve University College of Medicine, Dr. Bryan was formerly located at Children's Hospital, St. Louis, where she worked on a rheumatic fever project, and served as executive secretary for the Missouri Study of Child Health Services.

Section representatives to the Scientific Exhibit of the Atlantic City session of the American Medical Association, June 9-13, 1947, include: Dr. Paul A. Davis, Akron, Preventive and Industrial Medicine and Public Health, and Dr. J. Craig Bowman, Upper Sandusky, General Practice of Medicine.

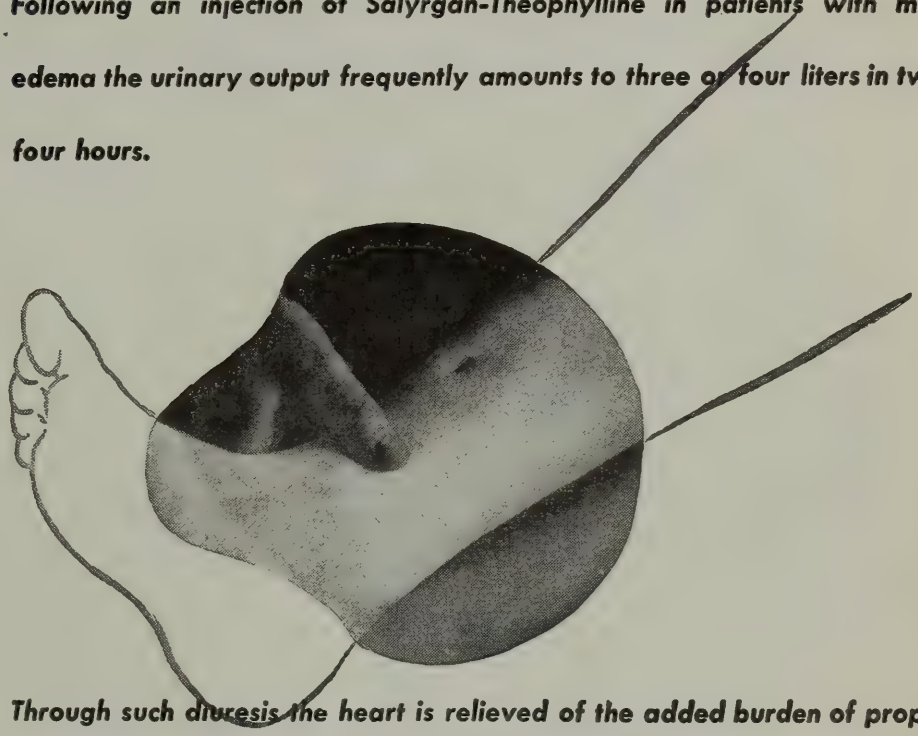
Hamilton—Dr. James A. Schaal, recently returned from military service, has been appointed assistant physician on the staff of the Butler County Health Service.

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In Memoriam

Blenn Rife Bales, M.D., Circleville; Starling Medical College, Columbus, 1900; aged 70; died Oct. 25; former member of the Ohio State Medical Association and the American Medical Association. Widely known as a naturalist, Dr. Bales had large collections of marine shells and had given a collection of bird eggs to the Ohio State Museum. He was a veteran of the Spanish-American War; member of the Methodist Church; a Mason, and a past-commander of Knights Templar. He was one of the early directors of the Circleville Pumpkin Show. For a number of years he was connected with the Norfolk and Western Railroad. Surviving are his widow, a daughter, a son, and a brother.

Frederick Beekel, M.D., Cleveland; University of Michigan Medical School, Ann Arbor, 1906; aged 65; died Nov. 3; former member of the Ohio State Medical Association and the American Medical Association. He was a member of the staff of the children's division of Cleveland City Hospital for 30 years, and was on the staff of Babies' and Children's Hospital in that city. He had practiced in Cleveland for 40 years. His widow and a daughter survive.

Edmund Raymond Bondy, M.D., Cleveland; University of Wooster Medical Department, Cleveland, 1898; aged 70; died Oct. 11; member of the Ohio State Medical Association and fellow of the American Medical Association. Dr. Bondy had practiced medicine in Cleveland since 1900, and was for many years physician for the *Cleveland Plain Dealer.* He retired from active practice eight years ago. For a number of years ending in 1932 he was examining physician for the Cleveland Boxing Commission. He was a captain in the Army Medical Corps in World War I, and was active in the American Legion. Dr. Bondy was a member of the Masonic Lodge. Surviving are a sister and two brothers.

John Summerfield Cherrington, M.D., Logan; Ohio Medical University, Columbus, 1897; aged 74; died Oct. 22; member of the Ohio State Medical Association and fellow of the American Medical Association. Dr. Cherrington was president of the Hocking County Medical Society in 1943; vice-president in 1942; and legislative committee chairman from 1930 through 1946. Dr. Cherrington and his brother, Dr. M. H. Cherrington, were founders of the present Hocking Valley Hospital in Logan, which they operated as the "Cherrington Hospital", from 1908 to 1944, when they sold the institution and resumed general practice. A school of nursing was conducted in connection with the hospital. Dr. Cherrington was a member of the Knights of Pythias and the United Brethren Church. His widow, two sons, and his brother survive.

George Minton Crawford, M.D., Arcadia, California; Baltimore Medical College, 1892; aged 84; died Nov. 7; former member of the Ohio State Medical Association and the American Medical Association. Dr. Crawford had practiced medicine in Lorain for 35 years prior to moving to California ten years ago. His widow survives.

Esgar Bowen Foltz, M.D., Akron; Medical College of Ohio, Cincinnati, 1889; aged 73; died Oct. 22; member of the Ohio State Medical Association and fellow of the American Medical Association. Dr. Foltz was a "world traveler" and an art collector as well as a physician. He began active practice in Akron in 1900, served as county jail physician for 20 years and participated in psychiatric work at probate court for 35 years. His father and his maternal grandfather preceded him in the practice of medicine in Akron. Annually he gave a $100 award to the highest ranking pre-medical student at Akron University and for years aided the blind people of Akron. He was a member of the board of trustees of the Akron Art Institute, and on the board of the Florence Crittenton Home.

George Thomas Gale, M.D., Newport, Ohio; Jefferson Medical College of Philadelphia, 1874; aged 95; died Oct. 9; former member of the Ohio State Medical Association and fellow of the American Medical Association. Dr. Gale had recently retired after having practiced medicine in Washington County for about 60 years. Dr. Gale's father, the late Dr. George W. Gale, also was a practicing physician. Surviving is a son, Dr. George H. Gale, Newport.

Charles Hickman Harris, M.D., New Paris; Starling Medical College, Columbus, 1890, and Jefferson Medical College of Philadelphia, 1891; aged 79; died Oct. 4; member of the Ohio State Medical Association and fellow of the American Medical Association. Dr. Harris was a practicing physician and druggest for 57 years. During World War I he was a captain in the U.S. Army Medical Corps. He was a member of the executive board of the local Methodist Church and was finance officer of the local American Legion post for 26 years. His widow, a son, a daughter, and a brother survive.

George F. Hutchinson, M.D., Marietta; aged 86; died Oct. 15; former member of the Ohio State Medical Association and the American Medical Association. Dr. Hutchinson had at-

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tended Starling Medical College of Columbus, and was granted a license in 1896 "by virtue of practice since 1891". He had retired a few years ago. Dr. Hutchinson was a member of the Congregational Church. A son and a daughter survive.

Florus Fremont Lawrence, M.D., Columbus; Columbus Medical College, Columbus, 1885; aged 83; died Oct. 26; member of the Ohio State Medical Association, the American Medical Association, and fellow of the American College of Surgeons. Dr. Lawrence had practiced medicine in Columbus for 50 years until his retirement in 1935. For 21 years he operated a private hospital in that city, and later was on the staff of White Cross Hospital. He served on the teaching staff of Starling Medical College from 1900 to 1907; Starling-Ohio Medical College from 1909 to 1914; and the Ohio State University College of Medicine from 1914 to 1917. He was a past-president of the Central Ohio Medical Society, forerunner of the present Columbus Academy of Medicine, of which he was the thirteenth president. He had contributed extensively to surgical literature. Dr. Lawrence served in the U.S. Army Medical Corps during both the Spanish-American War and World War I, and was a member of the Masonic Lodge, Alpha Mu Pi Omega, and Phi Beta Pi fraternities. Surviving are his widow, a son, Dr. G. P. Lawrence, a colonel in the Medical Corps of the regular Army, and a daughter.

Andrew Jackson Nellans, M.D., Cincinnati; Bennett College of Eclectic Medicine and Surgery, Chicago, 1896; aged 78; died Oct. 13. Dr. Nellans celebrated his 50th year of practice last March. He was a member of the Elmwood Lodge of Moose. Surviving are his widow, a son, Dr. Byron H. Nellans, Cincinnati, and a daughter.

John R. Nenninger, M.D., Westphir, Oregon; University of Cincinnati College of Medicine, 1940; aged 39; died Nov. 3; member of the Ohio State Medical Association and the American Medical Association. Dr. Nenninger had practiced at Silverton, near Cincinnati, previous to entering the Navy about four and one half years ago. After his release from the service with rank of lieutenant commander last year, he established practice in Wyoming, another Cincinnati suburb, later moving to Oregon. Surviving are his widow, a sister, and a brother.

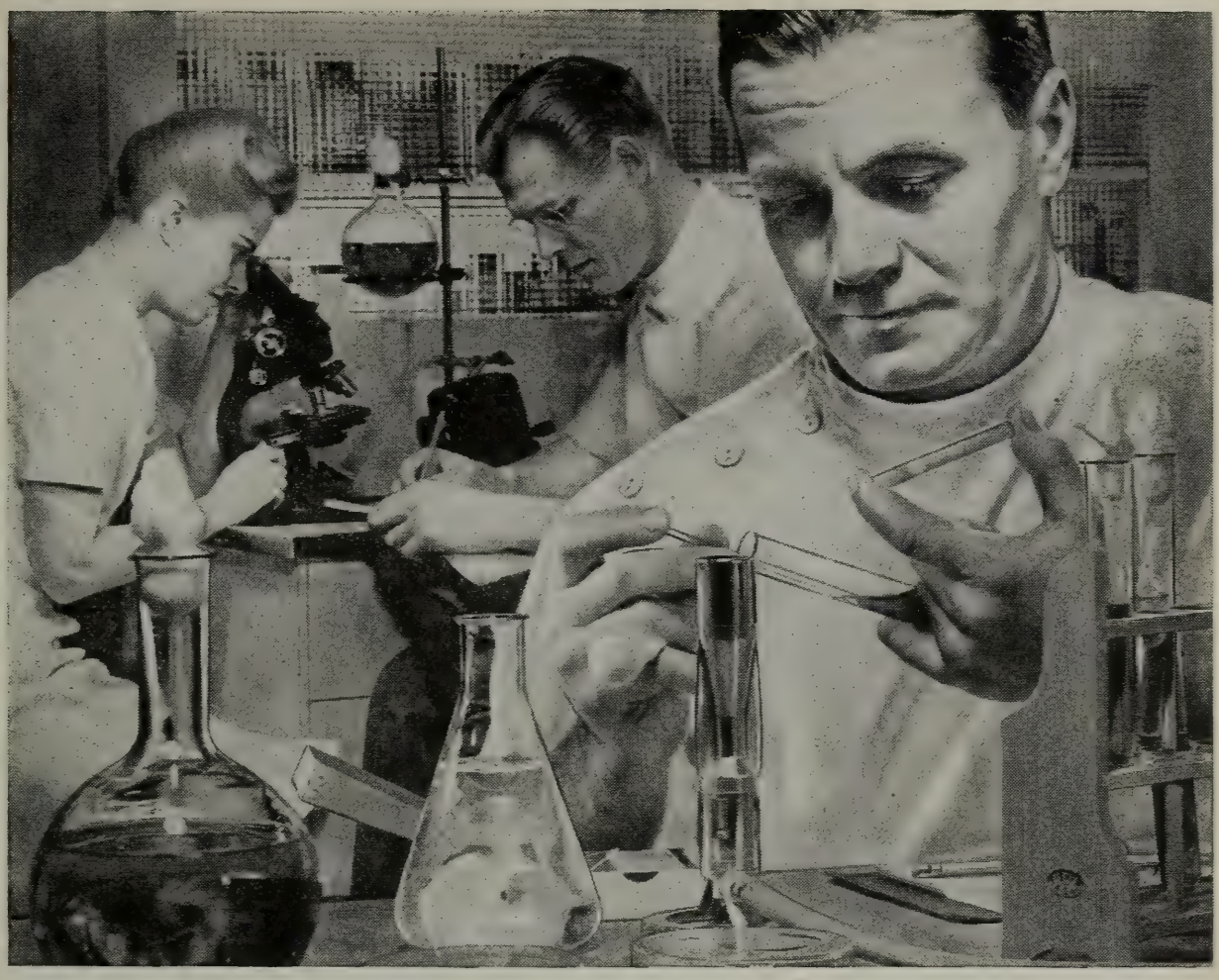
Frederick Arthur Rieckhoff, M.D., Ridgeville Corners; Ohio State University College of Medicine, 1917; aged 55; died Oct. 29; member of the Ohio State Medical Association and the American Medical Association. Dr. Rieckhoff had practiced medicine in Henry County for 15 years. Previous to that time he was located in Defiance. A veteran of World War I, Dr. Rieckhoff was a member of the Lutheran Church. Surviving are his widow, his parents, a brother, and a sister.

John J. Stitt, M.D., Risingsun; Ohio Medical University, Columbus, 1896; aged 77; died Sept. 21; member of the Ohio State Medical Association and the American Medical Association. Dr. Stitt had practiced medicine in Wood County for half a century. His widow survives.

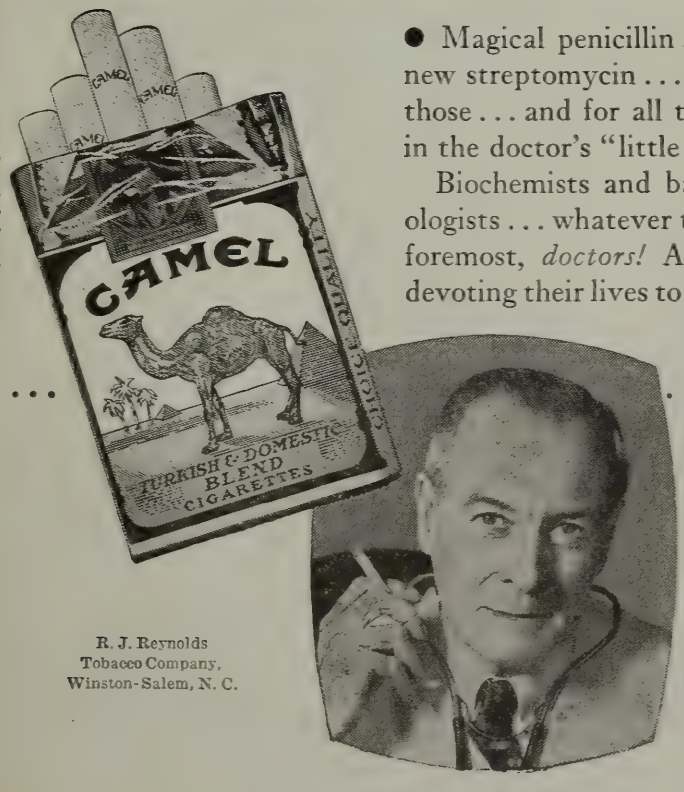
Lester Lyman Strong, M.D., Cleveland; Ohio State University College of Medicine, 1926; aged 51; died Nov. 4; member of the Ohio State Medical Association and fellow of the American Medical Association. After having practiced medicine in Cleveland for 18 years, Dr. Strong gave up his practice two years ago to devote full time to research on leukemia at University Hospital in Cleveland. In accordance with his wishes, corneal transplants from Dr. Strong's eyes were performed on three patients at University Hospital soon after his death. He was an overseas veteran of World War I, and until 1944, an associate staff member at Huron Road Hospital. Surviving are his widow, a son, his mother, and a brother.

Andrew Jay Timberman, M.D., Columbus; Miami Medical College, Cincinnati, 1894; aged 82; died Oct. 15; member of the Ohio State Medical Association and the American Medical Association; diplomate of the American Board of Ophthalmology; and fellow of the American Academy of Ophthalmology and Oto-Laryngology and of the American College of Surgeons. Dr. Timberman had studied in Vienna, London, and India. He was associated with the Ohio Medical University, Columbus, from 1889 to 1906; Starling-Ohio Medical College from 1907 to 1914; and the Ohio State University College of Medicine from 1914 to 1933. He was head of the department of ophthalmology from 1916 to 1926. He was an elder in the Presbyterian Church; member of the Masonic Lodge, the Optimist Club, and the Columbus Board of Education; and a former director of the Columbus Y.M.C.A. Surviving are his widow, five daughters, and a sister.

George Homer Zimmerman, M.D., Caldwell; Ohio State University College of Medicine, 1917; aged 57; died Oct. 7; member of the Ohio State Medical Association and the American Medical Association. Dr. Zimmerman was president of the Noble County Medical Society from 1919 through 1928. He served as secretary-treasurer of the society in 1946. He was a member of the Methodist Church, the Masonic Lodge, and Phi Rho Sigma fraternity. Survivors are his widow, two sons, a daughter, his mother, four brothers, and three sisters.



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Do You Know - - -

Additional civilian medical consultants to the Secretary of War recently appointed by the War Department, through the Surgeon General, include the following Ohioans: Dr. Johnson McGuire, Cincinnati, Internal Medicine; Dr. Robert J. Allison, Jr., Akron, General Surgery; Dr. N. Paul Hudson, Columbus, Preventive Medicine; Dr. Joseph T. Wearn, Cleveland, Nutrition. Consultants to the Army Epidemiologic Board, Army Medical Research and Development Board, include: Dr. John H. Dingle, Cleveland, and Dr. Albert B. Sabin, Cincinnati, Preventive Medicine and Epidemic Diseases.

* * *

There were 4,892 hernia claims filed with the State Industrial Commission during 1945. Sprains and strains were assigned as the cause of 4,771 cases, 11 were due to bruises, and 110 were unclassified.

* * *

Dr. George L. King, Alliance, is the new president of the board of trustees of Mt. Union College.

* * *

Construction of two 150-bed institutions for the treatment of alcoholics will be recommended to the next Legislature by Dr. Frank F. Tallman, State Commissioner of Mental Hygiene, according to news dispatches.

* * *

More than 70 physicians from all parts of the United States attended a six-day postgraduate course in hematology recently at the Ohio State University College of Medicine, under the direction of Dr. Charles A. Doan, Dean of the College.

* * *

Dr. Johnson McGuire, associate professor of medicine, University of Cincinnati College of Medicine, has been appointed a member of the Committee on Cardiovascular Disease of the National Research Council.

* * *

According to The Ohio Welfare Council, 7,000 persons were inmates of the 83 county homes in Ohio on Dec. 31, 1945. Of these, 59 per cent were 65 or older; 31 per cent, disabled by old age; 28 per cent, disabled by disease or sickness; 24 per cent, mentally ill, mentally deficient or epileptic; 12 per cent, deformed, blind, deaf, had lost a limb or were otherwise incapacitated.

* * *

The five-day clinical congress of the American College of Surgeons will be held in Cleveland, Dec. 16-20, with sessions at the Cleveland Public Auditorium, the Statler and Cleveland Hotels.

Over 24,000,000 people in the United States are now enrolled in Blue Cross Hospitalization plans. In Ohio, 2,300,000 persons are enrolled.

* * *

The use of dicumarol in the prevention of blood clots is being studied in a research program started by Dr. Roy W. Scott, professor of clinical medicine, at Western Reserve University School of Medicine, under a grant of $7,000 from the U.S. Public Health Service. Associated with him are Dr. Joseph M. Hayman, Jr., professor of clinical medicine and therapeutics, and Dr. Harold Feil, associate clinical professor of medicine.

* * *

The next written examination and review of case histories (Part I) for all candidates for certification by the American Board of Obstetrics and Gynecology will be held in various cities in the United States on Friday, Feb. 7, 1947. For further information and application blanks address: Paul Titus, M.D., secretary, 1015 Highland Bldg., Pittsburgh, Pa.

* * *

Dr. Cecil Striker, Cincinnati, has been appointed to a three-year term with the Metabolic Diseases Study Section of the National Institute of Health, Washington, D.C. In January, 1941, Dr. Striker was named the first president of the American Diabetes Association, of which he is now secretary.

* * *

The Committee on Postgraduate Medical Education of the American Trudeau Society is sponsoring a postgraduate course in thoracic diseases at the University of Wisconsin Medical School, Madison, Wisc., March 3-8, 1947. Further details can be obtained by addressing Dr. John D. Steele, Secretary, 1705 West Wisconsin Ave., Milwaukee 3.

* * *

After 36 years of distinguished service in the U.S. Public Health Service, Dr. Lewis Ryers Thompson, Assistant Surgeon General in the Bureau of State Services, was retired for medical disability on Nov. 1. Dr. Herman E. Hilleboe, who has been chief of the Tuberculosis Division since its inception in 1944, has been appointed Associate Chief of the Bureau of State Services, with the rank of Assistant Surgeon General.

* * *

Dr. Stanley D. Simon, assistant professor of medicine, University of Cincinnati College of Medicine, has been named medical director of the Hamilton County Chronic Disease Hospital. He succeeds Dr. Hiram B. Weiss, resigned.

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Activities of County Societies

First District

(COUNCILOR: E. O. SWARTZ, M.D., CINCINNATI)

BUTLER

"Psychosomatic Medicine" was the subject for discussion at the November 27 meeting of the Butler County Medical Society held in Hamilton. Dr. Herbert Warm was chairman of the meeting.—Bulletin.

CLINTON

The proposed Clinton Memorial Hospital was discussed at the October 29 meeting of the Clinton County Medical Society, held at the General Denver Hotel in Wilmington. A round-table discussion of candidates for public office was also held during the meeting.—R. W. DeCrow, M.D., secretary.

HIGHLAND

Dr. Richard W. Vilter, Cincinnati, addressed the luncheon meeting of the Highland County Medical Society, held at noon November 6, at the Stanforth's Restaurant in Hillsboro. His subject was "The Management of Acute Respiratory Diseases".—News clipping.

WARREN

Dr. O. W. Hoffman, Franklin, was re-elected president of the Warren County Medical Society at a meeting held in Lebanon November 5. Other officers named were Dr. Robert Wilson, Franklin, vice-president; Dr. Arch D. Harvey, Lebanon, secretary; Dr. Mary Cook, Waynesville, treasurer; Drs. Robert Blair, Lebanon, C. J. Haarlammert, Loveland, and A. F. Lippert, Pleasant Plain, Board of Censors. Delegates, Dr. Wilson and Dr. A. E. Stout, Waynesville. Dr. O. L. Layman, Franklin, was named to the Legislative Committee. During the scientific program Dr. E. A. Kindel, Cincinnati, presented a paper on "Relief of Pyloric Pain in Women by Surgical Resection of the Superior Hypogastric Plexus".—News clipping.

Second District

(COUNCILOR: H. C. MESSENGER, M.D., XENIA)

CLARK

"Pertinent Political Issues" were discussed at the October 24 luncheon meeting of the Clark County Medical Society, held at the Hotel Shawnee in Springfield. Dr. George M. Curtis, professor of surgery and research surgery, Ohio State University College of Medicine, spoke at a dinner meeting of the society November 20, also held at the Hotel Shawnee. The subject of Dr. Curtis' paper was, "The Treatment of Thyroid Disease".—Bulletin.

DARKE

The Darke County Medical Society met November 19 at the Wiebusch Manor in Greenville for a dinner meeting. The speaker was Dr. P. E. Dingle, Richmond, Indiana, who discussed "Management of the Occipital Posterior Position in Obstetrics".—W. D. Bishop, M.D., secretary.

MIAMI

The regular meeting of the Miami County Medical Society was held November 1, at the Piqua Hotel. Dr. R. Kent Finley, Dayton, discussed the proposed organization of a Miami County branch of the American Cancer Society. A. R. Mangus, Ph.D., professor of rural sociology, Ohio State University, spoke on the proposed mental hygiene survey in Miami County, which will constitute a pilot survey for the state.—G. A. Woodhouse, M.D., secretary.

MONTGOMERY

The regular meeting of the Montgomery County Medical Society was held November 1 at the University of Dayton. The legislative committee reported on candidates for election to public office.

Dr. Claude Starr Wright, department of medicine, Ohio State University College of Medicine, addressed the general practice section of the society October 30 at the Fidelity Auditorium in Dayton. Dr. Wright discussed recent advances in hematology.—N. E. Leyda, M.D., president.

Third District

(COUNCILOR: J. CRAIG BOWMAN, M.D., UPPER SANDUSKY)

ALLEN

Dr. Leo Dolan, Toledo, spoke at the October 15 meeting of the Allen County Academy of Medicine held at the Memorial Hospital Nurses Home, Lima.—News clipping.

Fourth District

(COUNCILOR: A. A. BRINDLEY, M.D., TOLEDO)

LUCAS

"The Doctors' Plan" was the subject for discussion at the November 1 general meeting of the Academy of Medicine of Toledo and Lucas County, held at the Academy Building. Speakers were Charles H. Coghlan, executive vice-president of Ohio Medical Indemnity, Inc., and Charles S. Nelson, executive secretary of the Ohio State Medical Association.

Nov. 15—Medical Section, Academy Building, "Medical Management of Hyperthyroidism", Dr. E. Perry McCullagh, Cleveland Clinic.

Nov. 22—Surgical Section, Academy Building, "Early Ambulation After Operation", Dr. Daniel

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J. Leithauser, chief surgeon, St. Joseph's Mercy Hospital, Detroit.—Bulletin.

SANDUSKY

At a meeting held October 17 by the Sandusky County Medical Society the members passed two resolutions regarding the condition of the Sandusky River. The first stated: "The river in its present condition is a definite menace to public health". The second: "The city (Fremont) should submit a bond issue to provide money with which to build a sewage treatment plant".—News clipping.

Fifth District

(COUNCILOR: FRED W. DIXON, M.D., CLEVELAND)

ASHTABULA

Dr. E. Perry McCullagh, of the Cleveland Clinic, spoke on "The Present Status of Endocrine Therapy" at the November 12 meeting of the Ashtabula County Medical Society held at the Hotel Ashtabula.—News clipping.

CUYAHOGA

The ninth annual Lower Lecture, made possible by a grant of money by Dr. William E. Lower, and presented by the Academy of Medicine of Cleveland and the Cuyahoga County Medical Society, was held at the Cleveland Medical Library Auditorium November 15. The lecturer selected for this year was Dr. Cornelius P. Rhoads, director of the Memorial Hospital for the Treatment of Cancer and Allied Diseases, New York City. His subject was "Recent Advances in the Treatment of Cancer".

Nov. 8—Combined meeting, Experimental Medicine Section of the Academy, and Cleveland Section of the Society for Experimental Biology and Medicine, Institute of Pathology Amphitheater: "Observations on Clinical Experiments with Streptomycin", Dr. Betty Gilson, and Dr. Robert F. Parker. "Mechanism of an Apparent Synergy between Azochloramid and Sulfanilamide", Dr. Morris Schaeffer. "Study of a Localized Outbreak of Influenza B", Dr. A. E. Feller. "Immunization Against Pneumococcal Pneumonia with Type Specific Capsular Polysaccharides", Dr. Richard G. Hodges.—Bulletin.

Sixth District

(COUNCILOR: PAUL A. DAVIS, M.D., AKRON)

MAHONING

The Mahoning County Medical Society will elect officers at the December 17 meeting, to be held at the Youngstown Club, Youngstown.—Bulletin.

PORTAGE

Dr. Carl Ernstene, Cleveland Clinic, talked on "Cardiac Emergencies" at the November 7 meet-

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ing of the Portage County Medical Society, which was held at the Robinson Memorial Hospital, Ravenna.—E. J. Widdecombe, M. D., secretary.

STARK

Dr. Edgar P. McNamee, Cleveland, president of the Ohio State Medical Association, discussed the Association's health program for Ohio, including Ohio Medical Indemnity, Inc., at the November 14 meeting of the Stark County Medical Society meeting at Mercy Hospital, Canton. Dr. McNamee was introduced Dr. R. L. Rutledge, Alliance, president-elect of the State Association.

On the same program, Dr. Lawrence M. Weinberger, Akron, spoke on "The Management of Cranial Cerebral Wounds in World War II". Dr. Weinberger's talk was illustrated by slides, showing actual cases and results in the war zone.—News clipping.

SUMMIT

Dr. George M. Curtis, professor of surgery and research surgery, Ohio State University College of Medicine, spoke on "Progress in the Treatment of Thyroid Disease" at the November 5 meeting of the Summit County Medical Society, held at City Hospital, Akron.—Bulletin.

Seventh District

(COUNCILOR: CARL A. LINCKE, M.D., CARROLLTON)

BELMONT

Speakers for the September 12 meeting of the Belmont County Medical Society were Dr. Leo Covert, Dr. Peter Lancione, and Dr. Homer Ring, all of Bellaire. These physicians presented a series of cases and case histories.—W. Miles Garrison, M.D., secretary.

JEFFERSON

Dr. E. W. Miskall, East Liverpool, addressed the October 22 meeting of the Jefferson County Medical Society in Steubenville, on the subject, "Coronary Heart Disease".—News clipping.

Eighth District

(COUNCILOR: ARTHUR J. TRONSTEIN, M.D., NEWARK)

MUSKINGUM

Dr. Edwin Stedem, Columbus, addressed the November 6 meeting of the Muskingum County Academy of Medicine on the subject, "Malignancies of the Uterus". The meeting was held at the University Club, Zanesville.—Beatrice T. Hagen, M.D., secretary.

Ninth District

(COUNCILOR: GILBERT MICKLETHWAITE, M.D., PORSTMOUTH)

LAWRENCE

At a recent meeting of the Lawrence County Medical Society, a resolution condemning "in-

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discriminate and wholesale signing of ballots for those purportedly unable to go to polls due to illness", was passed by the members. The society announced that blanks would be filled out only for those acutely ill or under the immediate care of the physician.—News clipping.

SCIOTO

Dr. Anson L. Brown, Columbus, discussed the subject, "The Laboratory in Medicine" at the regular meeting of the Hempstead Academy of Medicine, held November 11 at the General Hospital, Portsmouth. Dr. Dow Allard, Portsmouth, was in charge of the program.—G. E. Neff, M.D., secretary.

Tenth District

(COUNCILOR: H. M. CLODFELTER, M.D., COLUMBUS)

PICKAWAY

A luncheon meeting of the Pickaway County Medical Society was held November 1 at the Betz Restaurant in Circleville.—News clipping.

FRANKLIN

Dr. Earl H. Baxter, professor of pediatrics, Ohio State University College of Medicine, presented a paper on "Common Sense Pediatrics" at the November 4 meeting of the Columbus Academy of Medicine held in the Art Gallery, Columbus. Dr. Baxter discussed the more common problems met in caring for sick children and their families.

On November 18, Dr. Robert H. Zollinger, clinical professor of surgery, Ohio State University College of Medicine, discussed "Management of Acute Cholecystitis". This meeting was also held at the Columbus Gallery of Fine Arts.—Bulletin.

Eleventh District

(COUNCILOR: ROSS M. KNOBLE, M.D., SANDUSKY)

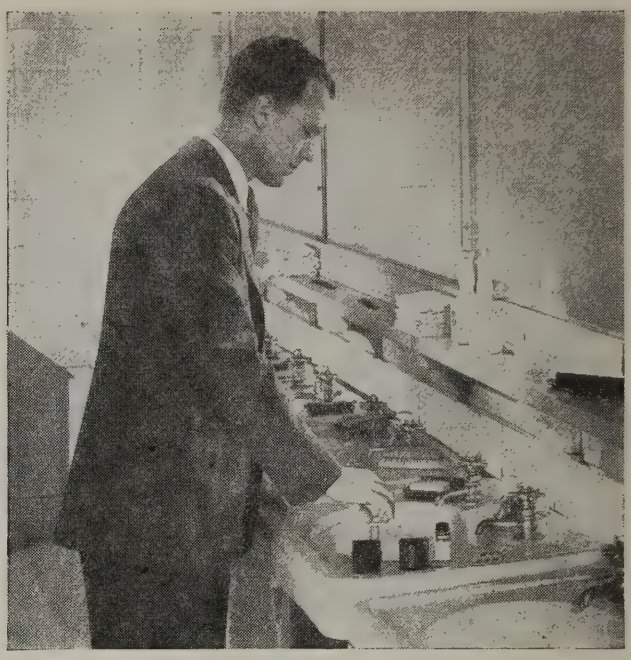
LORAIN

Dr. E. W. Netherton, department of dermatology, Cleveland Clinic, addressed the Lorain County Medical Society November 12 at Castle-on-the-Lake, Lorain. Dr. Netherton spoke on "Eczema or Dermatitis (including the differential diagnosis of contact dermatitis, atrophic dermatitis, seborrheic dermatitis, and infectious eczematoid dermatitis)".—L. H. Trufant, M.D., secretary.

RICHLAND

Dr. C. R. Damron, Mansfield, spoke on the subject, "Choosing Your Anesthetic", at a meeting of the Richland County Medical Society, held November 4 at the Mansfield-Leland Hotel.—News clipping.

Dr. Otto P. Geier retired recently, after nearly 34 years as director of employees' service at the Cincinnati Milling Machine Company.



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County Societies Being Asked for Data On Medical Personnel and Facilities

A 12-point questionnaire, designed to give a picture of the medical personnel, facilities, and health needs of every county in Ohio is being mailed to the secretary of each County Medical Society in the state by the Headquarters Office of the Ohio State Medical Association.

This is part of a study being made throughout the entire United States by the American Medical Association through its Joint Committee for Coordination of Medical Activities and the Committee on Rural Medical Service.

It is hoped that all secretaries will endeavor to complete the questionnaire promptly. Local committees should be requested to assist in filling out the blank if necessary.

The questionnaire is more complete than the one sent to secretaries recently by the Committee on Rural Health of the Ohio State Medical Association. For this reason the returns will give a more complete picture of the situation in all parts of the state.

Attached to each questionnaire is a state highway map for use by the county society in answering the second question.

The following questions are listed on the questionnaire:

1. Name of county.
2. Approximate population in the medical service area of which your county is the center . . . Circle on enclosed map area served by physicians in your county including parts of adjacent counties.
3. Number of physicians servicing this area.
4. How many physicians not previously in this area have come since 1944?
5. Are additional physicians needed in this area? Yes—No. General Practitioners . . . . Specialists. . . . What Specialists? . . . .
6. Number of hospital beds available to the area. . . .
7. Distance of nearest qualified hospitals to center of population of area. . . .
8. Is ambulance service for the transportation of patients from home to hospital readily available? Yes—No. Do you believe it would be desirable? . . . . Is ambulance privately, commercially, or publicly owned?
9. Is there widespread participation in the Blue Cross or other voluntary hospital insurance plans in your area? . . . . If not, do you think the extension of them is desirable?
10. Is there widespread participation in a voluntary medical prepayment plan or plans in your area? . . . . If not, do you think the extension of them is desirable? . . . . If no medical service plan exists, have you received inquiries concerning the possibilities of the development of a prepaid medical service plan?
11. The Hill-Burton legislation provides for



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public health centers and diagnostic clinics. Do you have such a center or clinic in your county? . . . . If so, is it operated with the approval or direction of the county medical society?

12. Additional comments.

WOMAN'S AUXILIARY NEWS

By MRS. FRED W. BROSIUS, MIDDLETOWN
Chairman, Publicity Committee

BELMONT

A joint dinner meeting of the Belmont County Medical Society and the Auxiliary was held November 14 at the Welcome Inn in Loydsville. Guest speaker was Carl J. Uhrmann, vice-president and general manager of the Imperial Glass Corporation, Bellaire.

BUTLER

The executive board of the Woman's Auxiliary to the Butler County Medical Society met for luncheon, Thursday, Nov. 14, at the Y.W.C.A. Hamilton. Mrs. C. J. Chamberlin, president, presided. Mrs. Paul A. Davis, Akron, was a guest.

FAYETTE

The Woman's Auxiliary to the Fayette County Medical Society was organized October 4, at Washington Court House.

A tea at the home of Mrs. N. M. Reiff, 404 Rawlings St., was attended by local physicians' wives and Mrs. Harold K. Mouser, president-elect of the State Auxiliary, and Mrs. George W. Cooperrider, district director.

Officers elected were: Mrs. N. M. Reiff, president; Mrs. Brent Welch, secretary, and Mrs. James E. Rose, treasurer.

The roster will include approximately twelve members.

FRANKLIN

The Woman's Auxiliary to the Columbus Academy of Medicine met September 16, at the home of Mrs. George T. Harding, Worthington, for Smörgasbord. Members of the social committee assisting the hostess were, Mrs. Myron Millhon, Mrs. Jerry Kerchner, Mrs. Wayne Brehm, Mrs. Roscoe Kahle, Mrs. R. W. Kissane, Mrs. Anton Oelgoetz, Mrs. Louis Praver, and Mrs. Thomas Rardin.

Mrs. J. F. Bateman served as chairman of the committee in charge of arrangements for the program and entertainment. New members were welcomed at this meeting.

Mrs. Earl H. Baxter, president, entertained the executive board with a luncheon recently at the Scioto Country Club.

The auxiliary members sponsored their annual benefit bridge and book review October 21, at the Columbus Gallery of Fine Arts. Proceeds from the affair will again be used for work in the

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field of occupational therapy, which is the project of the auxiliary.

Mrs. George I. Nelson reviewed "The Folded Leaf" by William Maxwell in the little theater at the Gallery. The bridge party was held in the Sessions Room and in the Children's Drawing Room.

Mrs. Ralph E. Ramey, general chairman of the affair, was assisted by the following: Mrs. Francis W. Gallagher, tickets; Mrs. C. C. Shinbach and Mrs. Raymond Ramey, prizes; Mrs. Shelby Gamble, arrangements; and Mrs. J. P. Bolton, vice-chairman and treasurer of the party. Mrs. R. B. Lawyer was chairman of hostesses.

HAMILTON

Officers of the Woman's Auxiliary to the Cincinnati Academy of Medicine for the ensuing year are: Mrs. David W. Heusinkveld, president; Mrs. Daniel Davies, vice-president; Mrs. Paul Woodward, president-elect; Mrs. Richard Bryant, recording secretary; Mrs. Robert Kotte, corresponding secretary; Mrs. J. J. Longacre, treasurer; and Mrs. J. L. Tuechter, Mrs. L. W. Sanders, and Mrs. Marion Blankenhorn, trustees.

Mrs. Samuel Bauer and Mrs. Robert Woolford of the program committee and Mrs. John Skavlem, hospitality chairman, have prepared a program of interesting meetings.

A luncheon was served in October at the home of Mrs. Paul Woodward, when Dr. William B. Bean spoke on "Wartime Developments in Medicine".

The auxiliary met at the home of Mrs. Louis B. Owens for tea, Tuesday, November 12. Mrs. David W. Heusinkveld is president of the auxiliary. Mrs. Forest Frank spoke on the "Maternal Health Program" and Mrs. Laude Lotspeich on "Character Development in Children." Reported by Mrs. C. Hofling and Mrs. Oscar Berghausen, publicity chairmen.

A Christmas party will be held in December at the residence of Mrs. Robert Cofield, with Mrs. Daniel Davies co-hostess. Mrs. Helen Martin will present the program of the Visiting Nurse Association.

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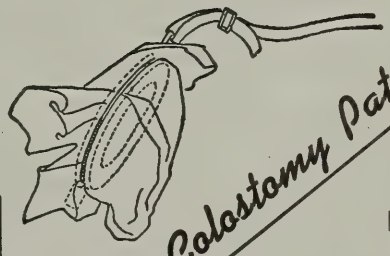
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Welsh for members and husbands will be held January 1.

A card party to raise funds for auxiliary projects is scheduled for February.

Mrs. J. J. Longacre will be chairman of a March luncheon at the Art Museum when Philip R. Adams will be guest speaker.

The annual meeting and tea is scheduled for April at the residence of Mrs. Orville Ramey.

A picnic luncheon will take place in May at the residence of Mrs. John Skavlem.

Chairmen of standing committees include Mrs. Paul Woodward and Mrs. J. L. Tuechter, membership; Mrs. Park Smith, public relations; Mrs. Daniel Early and Mrs. Ralph Eddy, legislation; Mrs. Ashton Welsh, project; Mrs. Samuel Bauer and Mrs. Robert Woodford, program; Mrs. Chas. A. Hofling and Mrs. Oscar Berghausen, publicity; Mrs. John Skavlem, hospitality; Mrs. Oliver Coe, historian; and Mrs. Robert Cofield and Mrs. Dale Fox, telephone.

PICKAWAY

At a luncheon meeting of physicians' wives of Pickaway County, November 5, it was voted to organize an auxiliary to the Pickaway County Medical Society.

The meeting was held at the home of Mrs. H. D. Jackson, and Mrs. Walter Heine, Circleville, was appointed temporary chairman. Officers will be elected at the December 3 meeting. About fifteen members are expected to enroll.

Mrs. Harold K. Mouser, Marion, state president-elect, and Mrs. George W. Cooperrider, tenth district director, assisted with the organization meeting.

ROSS

The Woman's Auxiliary to the Ross County Academy of Medicine met at the home of the president, Mrs. H. M. Crumley, Chillicothe. After a short business meeting, the members met with the Academy to hear a discussion of the Rh factor.

SCIOTO

The Woman's Auxiliary to the Hempstead Academy of Medicine celebrated its sixth birthday, Thursday, October 10, at the Hotel Hurth, Portsmouth. On this occasion the three "wartime" presidents, Mrs. Clyde M. Fitch, Mrs. A. P. Hunt and Mrs. William Singleton, were given special honors for their untiring efforts in making the auxiliary projects worthwhile. Gifts were presented by the first president, Mrs. S. L. Meltzer, and Mrs. W. C. McCann, president, paid a high tribute to their ability.

"Rh Factor in Medicine" was discussed by Dr. George D. Blume of Portsmouth, president of the Hempstead Academy of Medicine.

Serving with Mrs. McCann in office this year are: Mrs. L. B. Hatch, vice-president; Mrs. George D. Blume, secretary; and Mrs. George W. Martin, treasurer.

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The auxiliary was organized in October 1940, and now has a membership of sixty-three. Several local members have been honored with appointments as state officers.

Assisting Mrs. Meltzer as hostesses were: Mrs. Sol Asch, Mrs. Jackson Herbert, Mrs. C. H. Allen, Mrs. Clyde Fitch, Mrs. R. L. Wagner, and Mrs. W. A. Ray.

Mrs. Paul A. Davis, Akron, president of the State Auxiliary, was guest speaker at the November 13 meeting of the auxiliary held at the First Presbyterian Church in Portsmouth.

SUMMIT

Mrs. Donald Traul, Cuyahoga Falls, president of the Woman's Auxiliary to the Summit County Medical Society, gave a tea at her residence September 3, honoring new members.

The auxiliary is sponsoring a series of plays at the Showbox Theater, Akron, with September 13 as the opening date. Mrs. M. F. Bossart has charge of the distribution of tickets. The proceeds will be used for their Student Nurse Scholarship Fund.

Another project of the auxiliary is helping underprivileged girls at the Leggett School. This consists of saving fats for soap, supplying materials for dresses and giving them old hats to be made over. The girls are taught all the household arts and use the above articles for that purpose.

October 1, 200 members of the county society and the auxiliary met at the Idabelle Firestone Nurses Residence at 9:00 p.m. Social hour and refreshments were in charge of Mrs. W. A. Keitzer and committee.

A dinner dance was enjoyed by the members on October 12. The November 5th meeting was held at the Idabelle Firestone Nurses Residence, with Mrs. Robert Lemmon as chairman. Mrs. E. A. Simendinger and committee were in charge of social hour and refreshments.

TRUMBULL

A membership tea was held at the country club, September 27, by the Woman's Auxiliary to the Trumbull County Medical Society. Mrs. J. M. Gledhill, president, conducted a brief business session and introduced the new officers for 1946-47: Mrs. A. L. Sparks, president-elect; Mrs. David Mathie, vice-president; Mrs. Densmore Thomas, secretary; and Mrs. C. A. Bogue, treasurer. Mrs. Gledhill appointed committees for the ensuing year. Mrs. David Beers gave a report on the recent State Conference.

TUSCARAWAS

The Woman's Auxiliary to the Tuscarawas County Medical Society held its October meeting at the home of Mrs. Edgar C. Davis, Dover.

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Buckeye News Notes

Bowersville—Dr. Charles E. Ream has gone to Bradentown, Fla., for the winter, his "second vacation in 52 years".

Canton—Dr. H. H. Brueckner, formerly head of the Lima District Tuberculosis hospital, is the new superintendent of Molly Stark sanitorium. His successor at Lima is Dr. Ernest Holsted, a former assistant superintendent there, and more recently head of Pleasant View Sanitorium, Amherst.

Canton—Dr. John M. Van Dyke recently addressed the Massillon American Legion Auxiliary on the subject: "State Medicine and What It Means to Laity and the Medical Profession".

Cincinnati—Dr. Milton Rosenbaum, associate professor of psychiatry, University of Cincinnati College of Medicine, spoke on "Early Symptoms of Psychiatric Disturbances in Children", at a meeting of the Hamilton County Council of Parent-Teacher Associations.

Columbus—Dr. Harve M. Clodfelter, Councilor for the Tenth District of the Ohio State Medical Association, is the new president of the Metropolitan Health Council, a division of the Council of Social Agencies, planning organization for the Community Chest. He succeeds Dr. John H. Mitchell.

Columbus—Dr. Frank F. Tallman, State Commissioner of Mental Hygiene, was guest speaker at a meeting of the Springfield Altrusa Club.

Coshocton—Dr. Donald S. McDill, part-time health commissioner at Coshocton for the past four years, has been named to the full-time position of health commissioner for Wooster and Wayne Counties.

Dover—A veteran of both World Wars, Dr. Max Shaweker is the new commander of the local American Legion post.

Greenfield—Dr. John A. Mercer recently celebrated his 80th birthday. He has been practicing medicine for 58 years.

Harrod—Dr. M. L. Johnson, now 84 years old, has practiced medicine in the same office here for 61 years, and has "no intentions of retiring".

London—"Socialized, politically-controlled medicine has no place in our republic", said Dr J. A. Knapp in a recent address to the local Rotary Club.

Mansfield—Dr. W. B. Wild, Mansfield and Richland County Health Commissioner, has resigned to become a county health director in the Battle Creek, Mich., area. He will work in cooperation with the Kellogg Foundation.

Mansfield—Dr. Carl Damron has been certified as a diplomate of The American Board of Anesthesiology, Inc.

Piqua—"Rheumatic Fever" was the topic of a

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talk made by Dr. John T. Quirk at a meeting of the Kiwanis Club.

Steubenville—Dr. J. A. Haney, Adena, is the new health commissioner of Jefferson County. He succeeds Dr. John A. Bradley, who resigned Nov. 1. Dr. Bradley expects to make his home in San Diego, California.

Troy—Dr. Russell W. Gardner spoke on "General Anesthesia and Its Use in Modern Medicine", at a meeting of the Young Men's Business Club.

Van Wert—Dr. H. D. Underwood explained the development of anesthesia at a meeting of the Rotary Club.

Wilmington—Dr. R. W. DeCrow has been reappointed health commissioner of Clinton County for his fourth two-year term, beginning Jan. 1, 1947.

Wooster—"The Doctor Looks Ahead" was the topic of an address made by Dr. E. E. Judd at a meeting of the Kiwanis Club. Dr. Judd pointed out the objections to socialized medicine plans, and told of the advantages of voluntary prepaid health insurance sponsored by medical groups.

Youngstown—Dr. M. M. Szucs has been elected a fellow of the American College of Chest Physicians.

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To Discuss Rehabilitation Work

"Medical Rehabilitation of Hospitalized War Veterans" will be the subject of discussion when officials of Veterans Administration hospitals in Ohio, Michigan, and Kentucky convene December 10-12 at the Crile Hospital, Cleveland. Presiding will be Dr. Peter A. Volpe, chief of medical rehabilitation for the Columbus Branch office, supervising the Ohio-Michigan-Kentucky area.

The 33rd Degree in Masonry was conferred on Dr. Allan B. Rapp, Owensville, at the recent annual meeting of the Supreme Council of the Scottish Rite in Pittsburgh.

Tiffin—Dr. Bernard V. Lally, assistant city health commissioner at Akron, has been appointed health commissioner of Seneca County.

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